EM 7/8

Employee Benefits Survey Health Coding Manual

U.S. Department of Labor
Bureau of Labor Statistics
Office of Wages and Industrial Relations
Division of Occupational Pay and
Employee Benefit Levels

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BUREAU OF LABOR STATISTICS

OFFICE OF WAGES AND INDUSTRIAL RELATIONS

DIVISION OF OCCUPATIONAL PAY AND EMPLOYEE BENEFIT LEVELS

EMPLOYEE BENEFITS SURVEY

HEALTH CODING MANUAL

1986

HEALTH CODING MANUAL

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GENERAL CODING INSTRUCTIONS

A. For all questions, code the answer as if t[illegible]kers are age 43, have 15 years of service, and hav[illegible]s follows, based on occupational class: Professional a[illegible]e only, $40,700; Technical and Clerical only $18,700; and Production only $16,500; all salaried, $29,800; all classes, $23,200.

B. In rounding use the following rules:

   1. When the dropped digit is more than five, the preceding digit should be increased by one;

   2. When the dropped digit is less than five, the preceding digit should not be changed;

   3. When the dropped digit is five, the preceding digit should be increased by one if it is an odd number but should not be changed if it is an even number

   When provisions must be answered in months, years, etc., code answers to the nearest unit. (1 month = 4.345 weeks)

C. If the answer to the question is not listed, check the space by "Other" and describe it on a 3 x 5 card.

D. Unless otherwise indicated, only one of the possible answer listed under a question (other than "Remarks") should be checked. The instruction "check appropriate spaces" will be given when more than one of the answers may be checked.

E. Always check the answer for which blank spaces are filled.

F. Unless otherwise specified, round percent to nearest whole percent and round dollar amounts to nearest cent.

G. If the answer to a question varies by sex, job class, etc., unless otherwise indicated, answer the question by checking the space by the answer applicable to the mority of workers. Also, check the space by "Remarks" and on a 3 x 5 card identify the minority group and the provision applicable to this group.

H. All employee contribution questions relate to the monthly contribution. If the rates being analyzed relate to any other time period (weekly, bi-weekly, quarterly, etc.) convert to month(s), check space by "Remarks" and describe exact provision on a 3 x 5 card. For example, a weekly contribution rate should be multiplied by 4.345 to obtain its monthly equivalent.

I. In questions that apply, do not put in a zero to the left of the decimal when the answer does not require any digits to the left of the decimal. Example: 25¢ would be coded as .25. All digits must be filled in to the right of the decimal, even if they are zeroes.

PLAN IDENTIFICATION

000
1-3 EIN : ____________________
4-12

PN : ________
13-15

Benefit Area: (HEALTH) 01
16-17

Plan Sequence Number : _____
18-19

Date Originally Analyzed : Year_____/Month_____/Day_____
20-21 22-23 24-25

Analyst's Initials : ____
26-28

Verifier's Initials : ____
29-31

___ Action code
32

PLAN IDENTIFICATION

005
1-3

BLS Name of Plan: ______________________________
20-59

Official Name of Plan: ______________________________
60-129

____ Action code
130

010
1-3 Date of latest review and/or updating of this plan (leave blank if this is an original analysis)

Date: Year ______ 20-21 / Month ______ 22-23 / Day ______ 24-25

____ 26 Action code

020
1-3 Are there related plans? That is, do other plans provide benefits within the same benefit area that are additional or supplemental to those provided in this plan?

____ 20 No (SKIP TO QUESTION 030.)

____ 21 Yes (provide details below)

If there are other filings, identify the plan(s) and describe the type of relationship by inserting one of the following codes in "Type: ____":

1. Basic and described in a separate coding manual.
2. Supplemental and described in a separate coding manual.
3. Additive and included in this coding manual.

If code 1 or 2 apply, include Benefit Area code and Plan Sequence Number in order to identify the separate coding manual.

A. 22 EIN: ______ 23-31 PN: ______ 32-34 BA: ______ 35-36 PSN: ______ 37-38 Type: ____ 39

B. 40 EIN: ______ 41-49 PN: ______ 50-52 BA: ______ 53-54 PSN: ______ 55-56 Type: ____ 57

C. 58 EIN: ______ 59-67 PN: ______ 68-70 BA: ______ 71-72 PSN: ______ 73-74 Types: ____ 75

D. 76 EIN: ______ 77-85 PN: ______ 86-88 BA: ______ 89-90 PSN: ______ 91-92 Types: ____ 93

E. 94 EIN: ______ 95-103 PN: ______ 104-106 BA: ______ 107-108 PSN: ______ 109-110 Types: ____ 111

____ 112 Action code

OFFICIAL IDENTIFICATION

030
1-3 What is the identify and location of the plan sponsor?

Sponsor's Name: ______________________________ 20-79

____ Action code
80

050
1-3 What is the identity and location of the plan contact? If the contact person is the plan sponsor or plan administrator, write in whichever is applicable under Contact's Name and leave the other items blank.

Contact's Name : ______ 20-49

Title : ______ 50-89

City : ______ 90-109

State : ______ 110-111

Telephone Number: Area Code ______ 112-114 - ______ 115-117 - ______ 118-121

______ 122 Action code

SOURCE OF PLAN PROVISIONS

060
1-3 What is the source and effective date of the latest plan provisions (or latest amendment) analyzed?

____ Booklet from field
20

____ ERISA file
21

____ Telephone
22

____ 3111C
23

____ Booklet from telephone
24

____ HMO file
25

____ Other
26

Date: Year ______ /Month ______
27-28 29-30

Check if date is unknown ______
31

____ Action code
32

070
1-3 What is the effective date and content of later amendment (s) contained in the source material?

A. Year ______ /Month ______ /Provision ________________
20-21 22-23 24-73

B. Year ______ /Month ______ /Provision ________________
74-75 76-77 78-127

____ Action code
128

PLAN CHARACTERISTICS

080
1-3 What type of employer entity is the sponsor or co-sponsor of this plan?

___ 20 Single employer (includes subsidiary company)

___ 21 Multi-employer (employer contributes to trust fund on behalf of union members)

___ 22 Employer association (small employers banded together, such as New York Automotive Dealers Association)

___ 23 Government or state-administered (including temporary disability plans)

___ 24 Railroad Retirement Board

___ 25 Other

___ 26 Remarks

___ 27 Not determinable

___ 28 Not applicable

___ 29 Action code

090
1-3 Indicate whether or not any of the participants are in this plan as the result of a collective bargaining agreement. If the SPD says that the plan covers salaried or non-represented employees and also a specific bargaining unit which negotiates for coverage, check column 21.

___ Yes, participation for all members.
20

___ Yes, participation for some members.
21

___ No, participation does not result from an agreement.
22

___ Remarks
23

___ Not determinable
24

___ Not applicable
25

___ Action code
26

PLAN PARTICIPATION REQUIREMENTS

100
1-3 At what age, and after how many months from the start of employment, does the employee begin participation in this plan? Check appropriate spaces. If there are alternative requirements, code first the one applying to the lesser aged employee.

Record the minimum period of service required, including the administrative lags of one month or more. If the employee is covered the first of the month following employment, check "NO REQUIREMENTS." When participation requirements are in the form of hours, divide the number of hours by 173.6 to convert to months. Also check "Remarks" and enter the exact number of hours on a 3x5 card.

If the waiting period varies by type of benefit, describe for basic benefits here and for other benefits in QUESTION 105.

___ No requirements (immediate participation)
20

___ Age: ___ Service: ___ months
21 22-23 24-26

OR

___ Age: ___ Service: ___ months
27 28-29 30-32

___ Closed to new employees; plan covers employees hired before 19___
33 34-35

___ Other
36

___ Remarks
37

___ Not determinable
38

___ Not applicable
39

___ Action code
40

105 Does the waiting period vary by the type of benefit? Check appropriate
1-3 space(s).

___ No
20

___ Yes
21

___ Dental care has separate waiting period of ______months.
22 2325

___ Vision care has separate waiting period of ______months.
26 2729

___ Major Medical has separate waiting period of ______ months.
30 3133

___ Other
34

___ Remarks
35

___ Not determinable
36

___ Action code
37

110
1-3 What is the maximum age at which a newly-hired employee may join the plan?

___ None
20

___ Age ______
21 22-23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable
27

___ Action code
28

115
1-3 What percentage of the cost of the employee's benefits is paid by the employee? This is the cost of the employee's benefits only, not including dependents.

___ None (no employee contribution-SKIP TO QUESTION125)
20

___ ___ %
21 22-24

___ Other
25

___ Remarks
26

___ Not determinable
27

___ Not applicable
28

___ Action code
29

120 What is the employee's monthly contribution for an individual's benefits?
1-3 Code dollar amounts in cents.

___ $ ___.___
20 21-25

___ ___.___ % of monthly earnings (Round to nearest
26 27-30
hundredth of a percent.)

___ ___.___ % of monthly earning up to $ _____,
31 32-35 36-40

___.___ % of excess (Round to nearest hundredth
41-45
of a percent.)

___ ___.___ % of monthly earnings up to Social
45 46-49
Security Taxable Earnings Base, ___.___ % of excess
50-53
(Round to nearest hundredth of a percent.)

___ Contribution rate varies by earnings
54 (Define earnings and complete the following schedule)

Earnings are:

___ Hourly
55

___ Weekly
56

___ Monthly
57

___ Annual
58

120
1-3

IF EARNINGS ARE:	MONTHLY CONTRIBUTIONS ARE:
under $ ____.____ 59-65	$ ____.____ 66-70
up to $ ____.____ 71-77	$ ____.____ 78-82
up to $ ____.____ 83-89	$ ____.____ 90-94
up to $ ____.____ 95-101	$ ____.____ 102-106

Then, for each additional $ ____.____ 107-111 in earnings, up to $ ____.____ 112-118, contributions increase $ ____.____ 119-121 .

The maximum contribution is $ ____.____ 122-126

___ 127 Composite rate

___ 128 Varies by employee under cafeteria or flexible spending account program

___ 129 Other

___ 130 Remarks

___ 131 Not determinable

___ 132 Not applicable

___ 133 Action code

EMPLOYEE CONTRIBUTION FOR FAMILY BENEFITS

Describe employee's contribution for coverage for the family (employee, spouse, and one child). If rates vary by the family's size, also check "Remarks" and describe the rate schedule on a 3 x 5 card.

125/1-3 What percentage of the cost of family coverage is paid by employee?

__ 20 None (no employee contribution - SKIP TO QUESTION 135)

__ 21 _____% 22-24

__ 25 Other

__ 26 Remarks

__ 27 Not determinable

__ 28 Not applicable (no dependent coverage - SKIP TO QUESTION 135)

__ 29 Action code

130 What is the employee's monthly contribution for family coverage?
1-3 Code dollar amounts in cents.

___ $ ____.____ per month
20 21-25

___ ____.____% of earnings (Round to nearest hundredth of a percent.)
26 27-30

___ Composite rate
31

___ Varies by employee under cafeteria or flexible spending account program
32

___ Other
33

___ Remarks
34

___ Not determinable
35

___ Not applicable
36

___ Action code
37

132
1-3 Are employee contributions made on a pre-tax basis?

___ 20 Yes

___ 21 No

___ 22 Other

___ 23 Remarks

___ 24 Not determinable

___ 25 Not applicable

___ 26 Action code

135 What funding media provide basic hospital benefit coverage? Check
1-3 appropriate spaces.

___ 20 Labor/Management (includes union or employer health centers, self-funding)

___ 21 Blue Cross/Blue Shield

___ 22 Commercial insurance carrier

___ 23 Health Maintenance Organization

___ 24

___ 25 Other

___ 26 Remarks

___ 27 Not determinable

___ 28 Not applicable (No basic hospital benefit)

___ 29 Action code

140 1-3 What funding media provide basic surgical benefit coverage? Check appropriate spaces.

___ 20 Labor/Management (includes union or employer health centers, self-funding)

___ 21 Blue Cross/Blue Shield

___ 22 Commercial insurance carrier

___ 23 Health Maintenance Organization

___ 24

___ 25 Other

___ 26 Remarks

___ 27 Not determinable

___ 28 Not applicable (No basic hospital benefit)

___ 29 Action code

145
1-3 What funding media provide basic medical benefit coverage? Check appropriate spaces.

___ 20 Labor/Management (includes union or employer health centers, self-funding)

___ 21 Blue Cross/Blue Shield

___ 22 Commercial insurance carrier

___ 23 Health Maintenance Organization

___ 24

___ 25 Other

___ 26 Remarks

___ 27 Not determinable

___ 28 Not applicable (No basic medical benefit)

___ 29 Action code

150 What funding media provide major medical benefit coverage? Check appropriate
1-3 spaces.

___ 20 Labor/Management (includes union or employer health centers, self-funding)

___ 21 Blue Cross/Blue Shield

___ 22 Commercial insurance carrier

___ 23 Health Maintenance Organization

___ 24

___ 25 Other

___ 26 Remarks

___ 27 Not determinable

___ 28 Not applicable (No major medical benefit)

___ 29 Action code

155
1-3 What funding media provide dental coverage?

___ Labor/Management (includes union or employer health centers, self-funding)
20

___ Blue Cross/Blue Shield
21

___ Commercial insurance carrier
22

___ Health Maintenance Organization
23

___
24

___ Other
25

___ Remarks
26

___ Not determinable
27

___ Not applicable (No dental coverage)
28

___ Action code
29

160
1-3 What is the waiting period required before an individual can be covered for a pre-existing condition? Check appropriate spaces.

___ None (covered immediately)
20

___ Coverage becomes effective ______ months after joining the plan
21 22-23

___ Coverage becomes effective ______ months after which no treatment for that condition has been received
24 25-26

___ Varies from ______ to ______ months
27 28-29 30-31

___ The first $ ______ of charges for the pre-existing condition is covered
32 33-37

The above answers apply to:

___ Both Major Medical and Basic Benefits
38

___ Major Medical only
39

___ Basic benefits only
40

___ Other
41

___ Remarks
42

___ Not determinable
43

___ Not applicable (Pre-existing conditions are not covered)
44

___ Action code
45

165 What is the minimum age for insurance coverage of dependent children?
1-3

___ At birth (SKIP TO 175)
20

___ 14 days following birth
21

___ _______ days following birth
22 23-25

___ _______ months of age
26 27-28

___ Other
29

___ Remarks
30

___ Not determinable
31

___ Not applicable (NO DEPENDENT CHILDREN COVERAGE)
32 (SKIP TO QUESTION 180)

___ Action code
33

170
1-3 Will the waiting period in QUESTION 165 be eliminated if the child is ill due to disease, injury, or congenital abnormality, etc.?

___ Yes
20

___ No
21

___ Other
22

___ Remarks
23

___ Not determinable
24

___ Action code
25

175
1-3
What is the maximum age for insurance coverage for (non-disabled) dependent children? If the plan covers dependent students with no age limitation, code 99 in columns 25-26.

___ No maximum age
20

___ _____ years of age
21 22-23

___ _____ years of age if a full time student; otherwise age _____
24 25-26 27-28

___ Other
29

___ Remarks
30

___ Not determinable
31

___ Not applicable
32

___ Action code
33

180 May retirees participate in a group health insurance plan? If the
1-3 employer has no retirees and has not established a policy, check
"Not applicable."

___ No, SKIP TO QUESTION 210, DISABLED EMPLOYEE QUESTION
20

___ Yes
21

___ Other
22

___ Remarks
23

___ Not determinable (SKIP TO QUESTION 210, DISABLED EMPLOYEE QUESTION)
24

___ Not applicable (NO RETIREES, NO POLICY ESTABLISHED - SKIP TO QUESTION 210)
25

___ Action code
26

205
1-3
Describe the effect of retirement on the employees' health benefits.
Check appropriate spaces.

Retiree under 65	Retiree, over 65	
____ 20	____ 21	Cancelled immediately or within a month following termination
____ 22	____ 23	Continued ____ 24-25 months
____ 26	____ 27	Continued ____ 28-29 months
____ 30		Continued to age 65
____ 31	____ 32	Continued to age ____ 33-34
	____ 35	Continued indefinitely
____ 36	____ 37	Other
____ 38	____ 39	Continuation data are not available
	____ 40	Benefits are reduced only to the extent covered by Medicare
____ 41	____ 42	Benefits are reduced other than by Medicare or some benefits are ended
____ 43	____ 44	Benefits are increased
____ 45	____ 46	Benefits stay the same
____ 47	____ 48	Benefits data not available

Retiree, under 65	Retiree, over 65	
49	50	Retiree pays full cost
51	52	Retiree pays part of cost
53	54	Retiree pays no cost
55	56	Cost data not available
57	58	Other
59	60	Remarks
61	62	Not determinable
63	64	Not applicable
65	66	Action code

210
1-3 Describe the effect of total disability on the employees' health benefits. Check appropriate spaces.

____ 20 Cancelled immediately or within a month of termination

____ 21 Continued ____ (22-23) months

____ 24 Continued until the end of disability or ____ (25-26) months, whichever occurs first

____ 27 Continued until age ____ (28-29)

____ 30 Continued until retirement benefits are payable

____ 31 Continued indefinitely

____ 32 Continued, length not determinable

____ 33 Benefit level remains the same

____ 34 Benefit level reduced

____ 35 Benefit level increased

____ 36 Benefit level not determinable

____ 37 Employee pays full cost

____ 38 Employee pays no cost

____ 39 Employee pays some cost

____ 40 Premium not determinable

Other
______
41

Remarks
______
42

Not determinable
______
43

Not applicable
______
44

Action code
______
45

215
1-3 Describe the effect of the death of an active employee or retiree on the benefits of the survivors. If there is no retiree coverage, do not check any answers in column 2.

Active Employee dies	Retiree dies	
___ 20	___ 21	Cancelled immediately
___ 22	___ 23	Continued until end of month
___ 24		Continued for ______ months 25-26
	___ 27	Continued for ______ months 28-29
___ 30	___ 31	Continued until age ______ 32-33
___ 34	___ 35	Continued indefinitely
___ 36	___ 37	Benefit level remains the same
___ 38	___ 39	Benefit level decreases
___ 40	___ 41	Benefit level increases
___ 42	___ 43	Benefit level not determinable
___ 44	___ 45	Premium remains the same
___ 46	___ 47	Premium increases
___ 48	___ 49	Premium decreases
___ 50	___ 51	Premium not determinable
___ 52	___ 53	Other
___ 54	___ 55	Remarks
___ 56	___ 57	Not determinable
___ 58	___ 59	Not applicable
___ 60	___ 61	Action code

217 Describe the effect of a layoff on the employees' health benefit. Check
1-3 appropriate spaces.

___ Cancelled immediately or within a month of layoff (do not check
20 any addition answers)

___ Continued until the end of layoff or _____ months, whichever occur
21 first 22-23

___ Continued until rehired
24

___ Length of continuation varies by seniority or length of service
25

___ Continued, length not determinable
26

___ Benefit level remains the same
27

___ Benefit level reduced
28

___ Benefit level increased
29

___ Benefit level not determinable
30

___ Employee pays full cost
31

___ Employee pays not cost
32

___ Employee pays same cost
33

___ Employee cost not determinable
34

___ Other
35

___ Remarks
36

___ Not determinable
37

___ Not applicable (no layoff policy)
38

___ Action code
39

SECTION B - COVERED EXPENSES

SECTION B CODING INSTRUCTIONS

A. In the first question of each category of expenses (i.e., "Hospital Room and Board Coverage," "Hospital Miscellaneous Coverage," "Surgical Care Coverage," etc.) in Section B:

   1. When the expenses are paid for in full without any limitations, check only "Covered in full (CIF)" and do not check any other box in questions describing coverage of a category of expenses. Even if a Major Medical benefit covers these expenses, do not indicate such coverage in Section B.

   2. If benefits are covered subject to some limitations, like a fee schedule or an overall maximum, check "Covered subject to deductible, coinsurance, and/or maximum (CSDCM)." In cases in which expenses are "Covered in full (CIF)," for one set of circumstances and are CSDCM for another set of circumstances, check CSDCM, "remarks," and describe the CIF benefits, if necessary.

   3. If a category of expenses is covered under a check "Covered Under Basic Benefits."

   4. If a category of expenses is covered by the Major Medical Benefit, check "Covered Under Major Medical (CUMM)." Both CUBB and CUMM can be checked for the same category of expenditures.

   5. When the expenses are not covered under Basic Benefits or a Major Medical benefit, check "not applicable." If a category of expenses is covered only under special circumstances, for example, if Dental Care or Vision Care expenses are covered only in case of accidental injury, check "not applicable" in "Dental Care Coverage" or "Vision Care Coverage."

B. Variations in benefits which are not coded should be noted by checking "remarks" and describing the uncoded variations on a 3 x 5 card.

C. Code health benefits of the employee, and not those of the dependents, or retirees, unless otherwise indicated.

D. If benefits vary by area or by affiliation follow these rules:

   1. When the plan is provided by a health maintenance organization, code for benefits covered only in-the-service area. Ignore benefits covered outside-the-service area;

2. When the plan is provided by a Blue Cross or Blue Shield organization, code the benefits covered only in the member hospitals or for services by participating physicians, respectively.

HOSPITAL AND EXTENDED CARE

220 Describe coverage of hospital room and board charges. Check appropriate spaces.
1-3

___ Covered in full (usual + customary charges)
20

___ Covered subject to deductibles, coinsurance, and/or maximums
21

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No coverage of hospital room and board charges) SKIP TO QUESTION 230.
27

___ Action code
28

230
1-3 Describe coverage of hospital miscellaneous charges. Check appropriate spaces. (Hospital miscellaneous charges are miscellaneous expenses incurred while an inpatient, such as drugs, x-rays, and laboratory expenses.)

___ Covered in full (usual + customary charges)
20

___ Covered subject to deductibles, coinsurance, and/or maximums
21

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No coverage of hospital miscellaneous charges)
27

___ Action code
28

235
1-3 Describe coverage of charges for extended care. Check appropriate spaces.

___ Covered in full (usual + customary charges)
20

___ Covered subject to deductibles, coinsurance, and/or
21 maximums

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No coverage of extended care charges)
27 SKIP TO QUESTION 255.

___ Action code
28

240 Describe the coverage of extended care in a licensed extended care facility
1-3 that provides continuous nursing services. Check appropriate spaces.

___ No coverage (SKIP TO QUESTION 250)
20

    ___ Covered subject to ___ days of hospital
    21 22-24

    confinement prior to initial coverage of
    extended care.

    ___ Covered, but not subject to a requirement for
    25 prior hospital confinement

    ___ Hospital confinement requirement not determinable
    26

    ___ Covered subject to the basic hospital benefit
    27

    scheme maximum with ___ day of extended care
    28-29

    counted as ___ day of hospital confinement
    30-31

    ___ Covered but not subject to the basic hospital
    32 benefit scheme maximum.

    ___ Basic hospital benefit scheme maximum
    33 applicability not determinable

___ Other
34

___ Remarks
35

___ Not determinable
36

___ Not applicable
37

___ Action code
38

245 Is coverage in the extended care facility based on a percentage of the
1-3 semi-private room rate of the hospital in which previously confined?

___ No
20

___ Yes, covered at ______ % of semi-private room rate of the hospital
21 22-24

in which previously confined

___ Other
25

___ Remarks
26

___ Not determinable
27

___ Action code
28

250
1-3 Describe the coverage of extended care that is provided via home health care; including Visiting Nurse Associations. Check appropriate spaces.

___ No coverage
20

___ Covered subject to _____ days of hospital
21 22-24
confinement prior to initial coverage of extended care.

___ Covered, but not subject to a requirement
25 for prior hospital confinement.

___ Hospital confinement requirement not determinable
26

___ Covered subject to the basic hospital benefit
27

scheme maximum with _____ day of extended care
28-29

counted as _____ day of hospital confinement.
30-31

___ Covered but not subject to the basic hospital
32 benefit scheme maximum.

___ Basic hospital benefit scheme, maximum
33 applicability not determinable.

___ Other
34

___ Remarks
35

___ Not determinable
36

___ Not applicable
37

___ Action code
38

SURGICAL AND MEDICAL BENEFITS

255
1-3 Describe coverage of surgical care charges. Check appropriate spaces.

___ Covered in full (usual + customary charges)
20 SKIP TO QUESTION 280.

___ Covered subject to deductibles, coinsurance, and/or
21 maximums

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No coverage of surgical care charges)
27 SKIP TO QUESTION 280.

___ Action code
28

260
1-3
Is the surgical benefit determined by a surgical schedule?

___
20 No, not determined by a surgical schedule.
SKIP TO QUESTION 280.

___
21 Yes, surgical schedule in dollar amounts.
SKIP TO QUESTION 270.

___
22 Yes, surgical schedule of relative value units.

___
23 Yes, other surgical schedule (Check remarks and
describe on 3x5 card)

___
24 Other

___
25 Remarks

___
26 Not determinable

___
27 Not applicable

___
28 Action code

$\frac{265}{1\text{-}3}$ If the plan is based on a relative value schedule, what is the dollar value of each relative value unit? Check "Remarks" and identify the name and base year of the relative value schedule.

___ $ ___.___
20 21-25

___ Other
26

___ Remarks
27

___ Not determinable
28

___ Not applicable
29

___ Action code
30

270
1-3
What is the maximum amount payable for each of the following surgical procedures? Check appropriate spaces. Do not include benefits for surgeon's assistants or anesthesia.

___ A single surgical procedure $ _____ or _____ units
20 21-25 26-29

___ Appendectomy $ _____ or _____ units
30 31-34 35-37

___ Tonsillectomy for child $ _____ or _____ units
38 39-42 43-45

___ Hysterectomy $ _____ or _____ units
46 47-50 51-53

___ Normal delivery $ _____ or _____ units
54 55-59 60-62

___ Other
63

___ Remarks
64

___ Not determinable
65

___ Not applicable
66

___ Action code
67

MEDICAL BENEFIT INSTRUCTIONS

1. Code for physician's visits, not consultations.
2. Code for physician's visits unrelated to surgery, not visits pertaining to surgery.
3. Code for established patients, not new patients.

280 Describe coverage of in-hospital medical charges. Check appropriate
1-3 spaces.

___ Covered in full (usual + customary charges)
20

___ Covered subject to deductibles, coinsurance, and/or maximums
21

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No coverage of in-hospital medical charges)
27

___ Action code
28

285 Describe coverage of charges for medical treatment in the office. Check appropriate spaces. When medical benefits are provided both in a doctor's office and an employer or union health center, code most liberal benefit, check "Remarks" and describe less liberal benefit on a 3 x 5 card.

___ Covered in full (usual + customary charges)
20

___ Covered subject to deductibles, coinsurance, and/or maximums
21

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No coverage of office medical charges)
27

_ Action code
28

MATERNITY

290 Who is covered for maternity charges? Check appropriate spaces.
1-3

____ Female employee
20

____ Spouse of employee
21

____ Dependents other than spouse
22

____ Other
23

____ Remarks
24

____ Not determinable
25

____ Not applicable
26

____ Action code
27

DIAGNOSTIC X-RAY AND LABORATORY TESTING BENEFIT

325
1-3 Describe coverage of charges for diagnostic X-ray and lab testing. Check appropriate spaces.

___ 20 Covered in full (usual + customary charges)

___ 21 Covered subject to deductibles, coinsurance, and/or maximums

___ 22 Covered under Basic Benefits

___ 23 Covered under Major Medical

___ 24 Other

___ 25 Remarks

___ 26 Not determinable

___ 27 Not applicable (No diagnostic X-ray and lab testing coverage) SKIP TO QUESTION 345.

___ 28 Action code

330 Identify the locations where coverage is provided for diagnostic x-ray and
1-3 laboratory testing, other than under the Hospital Miscellaneous benefit.
Check appropriate spaces.

____ Hospital inpatient
20

____ Hospital outpatient
21

____ Doctor's office
22

____ Other
23

____ Remarks
24

____ Not determinable
25

____ Not applicable
26

____ Action code
27

335 / 1-3 **Is the diagnostic X-ray and laboratory (DXL) benefit determined by a DXL schedule?**

___ 20 No. SKIP TO QUESTION 345.

___ 21 Yes

___ 22 Other

___ 23 Remarks

___ 24 Not determinable

___ 25 Not applicable

___ 26 Action code

340 What is the maximum amount paid for each of the following tests?
1-3 (Enter the dollar amount)

(If a Relative Value Schedule (RVS) was used, multiply the assigned units by the conversion factor, enter the product, check "Remarks," and identify the conversion factor, name and date of the RVS.)

___ EKG $ ___
20 21-23

___ Chest X-ray
24 (2 views) $ ___
25-27

___ Blood Count,
28 (Complete) $ ___
29-31

___ Other
32

___ Remarks
33

___ Not determinable
34

___ Not applicable
35

___ Action code
36

OUTPATIENT CARE AND SPECIAL ACCIDENT BENEFIT

345
1-3 Describe coverage of charges for care in the outpatient department of a hospital. Check appropriate spaces.

___ 20 No outpatient care coverage. SKIP TO QUESTION 365.

___ 21 Covered in full

___ 22 Covered subject to deductibles, coinsurance, and/or maximums

___ 23 Covered under Basic Benefits

___ 24 Covered under Major Medical

___ 25 Other

___ 26 Remarks

___ 27 Not determinable

___ 28 Not applicable (No coverage of outpatient care nor special benefit for accidents) SKIP TO QUESTION 370.

___ 29 Action code

350/1-3 Which of the following charges by the outpatient department of a hospital are subject to limitations? If more than one limitation, code limitations in Section C for the first answer checked below.

___ Surgical procedure
20

___ Rehabilitative or physical therapy
21

___ Treatment for chronic illness (Not emergencies)
22

___ Other
23

___ Remarks
24

___ Not determinable
25

___ Not applicable
26

___ Action code
27

355/1-3 Are emergency room charges treated the same as in-patient hospital charges?

___ Yes
20

___ Not (check appropriate spaces)
21

___ Separate deductible of $ ___
22 23-27

___ Not deductible (separate hospital deductible)
28

___ Different coinsurance
29

___ Other
30

___ Remarks
31

___ Not determinable
32

___ Not applicable
33

___ Action code
34

365 Describe coverage of charges for accidental bodily injury under a special
1-3 benefit (applicable to all charges and not limited to outpatient charges). Check appropriate spaces.

___ 20 No special benefit

___ 21 Covers charges for services rendered within

___ 22-24 days of an accident.

___ 25 Covers charges in full.

___ 26 Covers first dollar expenses up to $ ___ 27-31.

___ 32 Covers ___ 33-34 % of expenses.

___ 35 Other

___ 36 Remarks

___ 37 Not determinable

___ 38 Not applicable

___ 39 Action code

PRESCRIPTION DRUGS AND PRIVATE DUTY NURSING

370
1-3 Describe coverage of charges for prescription drugs-non-hospital. Check appropriate spaces.

___ Covered in full (usual + customary) charges
20

___ Covered subject to deductibles, coinsurance, and/or maximums
21

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No prescription drug coverage)
27

___ Action code
28

375
1-3 Describe coverage of charges for private duty nursing. Check appropriate spaces. Private Duty Nursing is full-time nursing care by a registered nurse (R.N.), or by a licensed practical nurse (L.P.N.) authorized by a physician. Code coverage for a registered nurse rather than a licensed practical nurse unless the former is not mentioned.

___ 20 Covered in full (usual + customary charges)

___ 21 Covered subject to deductibles, coinsurance, and/or maximums

___ 22 Covered under Basic Benefits

___ 23 Covered under Major Medical

___ 24 Other

___ 25 Remarks

___ 26 Not determinable

___ 27 Not applicable (No private duty nursing care coverage)

___ 28 Action code

MENTAL HEALTH CARE BENEFIT

380
1-3 Describe coverage of charges for mental health care. Check appropriate spaces.

___ 20 Covered in full (usual + customary charges)

___ 21 Covered subject to deductibles, coinsurance, and/or maximums

___ 22 Covered under Basic Benefits

___ 23 Covered under Major Medical

___ 24 Other

___ 25 Remarks

___ 26 Not determinable

___ 27 Not applicable (No mental health care coverage) SKIP TO QUESTION 405.

___ 28 Action code

385
1-3 Are hospital confinements due to nervous or mental disorders (i.e., confinement for psychiatric care) covered?

___ No (SKIP TO QUESTION 395)
20

___ Yes
21

___ Other
22

___ Remarks
23

___ Not determinable
24

___ Not applicable
25

___ Action code
26

390
1-3 Is coverage of hospital confinement in a general hospital for mental illness exactly the same as for other illnesses? (Check "NO" even if the differences are minimal)

___ No
20

___ Yes
21

___ Other
22

___ Remarks
23

___ Not determinable
24

___ Not applicable
25

___ Action code
26

395
1-3 Identify the locations or special circumstances for which coverage is available for mental health care. Check appropriate spaces.

___ Hospital out-patient charges
20

___ Charges of an institution which specializes
21 in the diagnosis and treatment of mental illness

___ Services of a clinical psychologist
22

___ Out-of-hospital physician's treatment
23

___ Day/night care facility
24

___ Other
25

___ Remarks
26

___ Not determinable
27

___ Not applicable (none of the above expenses)
28

___ Action code
29

400
1-3 Describe coverage of charges incurred in a special mental or psychiatric hospital which varies from coverage in a general hospital. Check appropriate spaces.

___ No coverage
20

___ ______ % of hospital charges
21 22-23

___ $ ______ per day
24 25-27

___ $ ______ per year
28 29-33

___ $ ______ per confinement
34 35-39

___ $ ______ per lifetime
40 41-46

___ ______ days per year
47 48-50

___ ______ days per confinement
51 52-54

___ ______ days per lifetime
55 56-59

___ Other
60

___ Remarks
61

___ Not determinable
62

___ Not applicable (Covered the same as in a general hospital)
63

___ Action code
64

DENTAL CARE BENEFIT

405 How are DENTAL CARE charges covered? Check appropriate spaces.
1-3

___ 20 Covered in full (usual + customary charges)

___ 21 Covered subject to deductibles, coinsurance, and/or maximums

___ 22 Covered under Basic Benefits

___ 23 Covered under Major Medical

___ 24 Other

___ 25 Remarks

___ 26 Not determinable

___ 27 Not applicable (No dental care coverage) SKIP TO QUESTION 485.

___ 28 Action code

$\frac{410}{1\text{-}3}$ Are employees covered for dental care?

___ No
20

___ Yes
21

___ Other
22

___ Remarks
23

___ Not determinable
24

___ Not applicable
25

___ Action code
26

$\frac{415}{1\text{-}3}$ Are spouses of employees covered for dental care?

___ No
20

___ Yes
21

___ Other
22

___ Remarks
23

___ Not determinable
24

___ Not applicable
25

___ Action code
26

420
1-3 Are (non-disabled) dependent children covered for dental care?

___ No
20

___ Yes
21

___ Other
22

___ Remarks
23

___ Not determinable
24

___ Not applicable
25

___ Action code
26

If a Relative Value Schedule (RVS) was used to determine coverage of dental procedures specified in questions 425-460, multiply the designated units by the conversion factor, code the product or dollar amount for that procedure when applicable, check "Remarks" and identify the conversion factor, name and date of the RVS.

425
1-3 Describe coverage of charges for prophalaxis and routine examinations.

___
20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___
21 Subject to copayment.

___
22 Subject to a $ _____ maximum payable.
23-25

___
26 Subject to _____ % of usual, reasonable or
27-29
customary charges.

___
30 Subject to _____ % of usual, reasonable, or
31-33
customary charges up to $ _____ maximum payable.
34-36

___
37 Subject to _____ % of usual, reasonable, or
38-40
customary charges up to $ _____ of plan paid
41-45
expenses and _____ % thereafter.
46-48

___
49 Subject to an unspecified separate maximum dollar amount.

___
50 Subject to incentive schedule.

___
51 Other

___
52 Remarks

___
53 Not determinable

___
54 Not applicable (No coverage of prophalaxis and routine examinations)

___
55 Action code

430
1-3 Describe coverage of charges for fillings (i.e., amalgam filling--one surface is most common procedure listed.)

___ 20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___ 21 Subject to copayment.

___ 22 Subject to a $ ___ 23-26 maximum payable.

___ 27 Subject to ___ 28-30 % of usual, reasonable or customary charges.

___ 31 Subject to ___ 32-34 % of usual, reasonable, or customary charges up to $ ___ 35-38 maximum payable.

___ 39 Subject to ___ 40-42 % of usual, reasonable, or customary charges up to $ ___ 43-47 of plan paid expenses and ___ 48-50 % thereafter.

___ 51 Subject to an unspecified separate maximum dollar amount.

___ 52 Subject to incentive schedule.

___ 53 Other

___ 54 Remarks

___ 55 Not determinable

___ 56 Not applicable (No coverage of fillings)

___ 57 Action code

435
1-3 Describe coverage of charges for dental surgery. Code for simple fracture of mandible, or if not listed, the most expensive procedure listed. If dental-surgical procedures are listed only in a surgical fee schedule, check "No coverage of dental surgery."

___ 20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___ 21 Subject to copayment.

___ 22 Subject to a $ ___ 23-27 maximum payable.

___ 28 Subject to ___ 29-31 % of usual, reasonable or customary charges.

___ 32 Subject to ___ 33-35 % of usual, reasonable, or customary charges up to $ ___ 36-40 maximum payable.

___ 41 Subject to ___ 42-44 % of usual, reasonable, or customary charges up to $ ___ 45-51 of plan paid expenses and ___ 52-54 % thereafter.

___ 55 Subject to an unspecified separate maximum dollar amount.

___ 56 Subject to incentive schedule.

___ 57 Other

___ 58 Remarks

___ 59 Not determinable

___ 60 Not applicable (No coverage of dental surgery)

___ 61 Action code

440 Describe coverage of charges for inlays. Code for 3-surface gold
1-3 inlays, or if not listed, the most expensive procedure listed.

___ 20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___ 21 Subject to copayment.

___ 22 Subject to a $ _____ 23-26 maximum payable.

___ 27 Subject to _____ 28-30 % of usual, reasonable or customary charges.

___ 31 Subject to _____ 32-34 % of usual, reasonable, or customary charges up to $ _____ 35-38 maximum payable.

___ 39 Subject to _____ 40-42 % of usual, reasonable, or customary charges up to $ _____ 43-47 of plan paid expenses and _____ 48-50 % thereafter.

___ 51 Subject to an unspecified separate maximum dollar amount.

___ 52 Subject to incentive schedule.

___ 53 Other

___ 54 Remarks

___ 55 Not determinable

___ 56 Not applicable (No coverage of inlays)

___ 57 Action code

445 / 1-3 Describe coverage of charges for crowns. Code for porcelain jack crown with metal thimble, or if not listed, the most expensive procedure listed.

___ 20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___ 21 Subject to copayment.

___ 22 Subject to a $ _____ (23-26) maximum payable.

___ 27 Subject to _____ (28-30) % of usual, reasonable or customary charges.

___ 31 Subject to _____ (32-34) % of usual, reasonable, or customary charges up to $ _____ (35-38) maximum payable.

___ 39 Subject to _____ (40-42) % of usual, reasonable, or customary charges up to $ _____ (43-47) of plan paid expenses and _____ (48-50) % thereafter.

___ 51 Subject to an unspecified separate maximum dollar amount.

___ 52 Subject to incentive schedule.

___ 53 Other

___ 54 Remarks

___ 55 Not determinable

___ 56 Not applicable (No coverage of crowns)

___ 57 Action code

450
1-3 Describe coverage of charges for periodontal care. Code for surgical gingivectomy per quadrant, or if not listed, the most expensive procedure listed). Check appropriate space(s).

___ 20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___ 21 Subject to copayment.

___ 22 Subject to a $ ___ (23-27) maximum payable.

___ 28 Subject to ___ (29-31) % of usual, reasonable or customary charges.

___ 32 Subject to ___ (33-35) % of usual, reasonable, or customary charges up to $ ___ (36-40) maximum payable.

___ 41 Subject to ___ (42-44) % of usual, reasonable, or customary charges up to $ ___ (45-51) of plan paid expenses and ___ (52-54) % thereafter.

___ 55 Subject to a lifetime maximum of $ ___ (56-59).

___ 60 Subject to an unspecified separate maximum dollar amount.

___ 61 Subject to incentive schedule.

___ 62 Other

___ 63 Remarks

___ 64 Not determinable

___ 65 Not applicable (No coverage of periodontal care)

___ 66 Action code

455
1-3 Describe coverage of charges for dental X-rays. Code for a complete series of dental X-rays, or if not listed, the most expensive procedure listed.

___ 20 Subject to coinsurance which varies by amount of expenses for two or more procedures.

___ 21 Subject to copayment.

___ 22 Subject to a $ ____ 23-26 maximum payable.

___ 27 Subject to ____ 28-30 % of usual, reasonable or customary charges.

___ 31 Subject to ____ 32-34 % of usual, reasonable, or customary charges up to $ ____ 35-38 maximum payable.

___ 39 Subject to ____ 40-42 % of usual, reasonable, or customary charges up to $ ____ 43-47 of plan paid expenses and ____ 48-50 % thereafter.

___ 51 Subject to an unspecified separate maximum dollar amount.

___ 52 Subject to incentive schedule.

___ 53 Other

___ 54 Remarks

___ 55 Not determinable

___ 56 Not applicable (No coverage of dental X-rays)

___ 57 Action code

460 Describe coverage of charges for orthodontia.
1-3

___ Subject to coinsurance which varies by amount of expenses for
20 two or more procedures.

___ Subject to copayment.
21

___ Subject to a $ _____ lifetime maximum payable.
22 23-27

___ Subject to _____ % of usual, reasonable or
28 29-31

customary charges.

___ Subject to _____ % of usual, reasonable, or
32 33-35

customary charges up to $ _____ lifetime maximum payable.
36-40

___ Subject to _____ % of usual, reasonable, or
41 42-44

customary charges up to $ _____ of plan paid
45-50

expenses and _____ % thereafter.
51-53

___ Subject to an unspecified separate maximum
54 dollar amount.

___ Subject to incentive schedule.
55

___ Other
56

___ Remarks
57

___ Not determinable
58

___ Not applicable (No coverage of orthodontia)
59

___ Action code
60

465 Which of the following charges are subject to an incentive schedule?
1-3 Check appropriate spaces.

___ No dental incentive schedule
20

___ Prophalaxis and exams
21

___ X-rays
22

___ Fillings
23

___ Dental surgery
24

___ Inlays
25

___ Crowns
26

___ Periodontal care
27

___ Orthodontia
28

Describe the incentive schedule;

Covered at ______ % for the 1st ______ months,
29-31 32-33
______ % for the next ______ months,
34-36 37-38
______ % for the next ______ months,
39-41 42-43
______ % for the next ______ months,
44-46 47-48
______ % thereafter
49-51

___ Other
52

___ Remarks
53

___ Not determinable
54

___ Action code
55

470 Describe any deductible(s) that apply to dental coverage. Check appropriate
1-3 spaces.

	Yearly Deductible		Lifetime Deductible	
	1	2	1	2
	$ ___ 20-22	$ ___ 23-25	$ ___ 26-28	$ ___ 29-31
Prophalaxis & Exams	___ 32	___ 33	___ 34	___ 35
X-rays	___ 36	___ 37	___ 38	___ 39
Fillings	___ 40	___ 41	___ 42	___ 43
Dental surgery	___ 44	___ 45	___ 46	___ 47
Inlays	___ 48	___ 49	___ 50	___ 51
Crowns	___ 52	___ 53	___ 54	___ 55
Periodontal care	___ 56	___ 57	___ 58	___ 59
Orthodontia	___ 60	___ 61	___ 62	___ 63

___ 64 Subject to major medical deductible

___ 65 Other

___ 66 Remarks

___ 67 Not determinable

___ 68 Not applicable

___ 69 Action code

475 Describe any combined maximum(s) that apply to dental coverage. Check
1-3 appropriate spaces.

	Yearly Max.		Lifetime Max.	
	1	2	1	2
	$ ___ 20-24	$ ___ 25-29	$ ___ 30-34	$ ___ 35-39
Prophalaxis & Exams	___ 40	___ 41	___ 42	___ 43
X-rays	___ 44	___ 45	___ 46	___ 47
Fillings	___ 48	___ 49	___ 50	___ 51
Dental surgery	___ 52	___ 53	___ 54	___ 55
Inlays	___ 56	___ 57	___ 58	___ 59
Crowns	___ 60	___ 61	___ 62	___ 63
Periodontal care	___ 64	___ 65	___ 66	___ 67
Orthodontia	___ 68	___ 69	___ 70	___ 71

___ 72 Subject to major medical maximum

___ 73 Other

___ 74 Remarks

___ 75 Not determinable

___ 76 Not applicable

___ 77 Action code

480
1-3
Describe any individual copayments required for the following procedures. Check appropriate space(s).

___ Prophalaxis and Exams $__________
20 21-22

___ X-rays $__________
23 24-25

___ Fillings $__________
26 27-28

___ Dental Surgery $__________
29 30-32

___ Inlays $__________
33 34-36

___ Crowns $__________
37 38-40

___ Periodontal Care $__________
41 42-44

___ Orthodontia (per procedure) $__________
45 46-49

___ Other
50

___ Remarks
51

___ Not determinable
52

___ Not applicable
53

___ Action Code
54

VISION CARE BENEFIT

485
1-3 Describe coverage of charges for vision care. Check appropriate spaces. If vision care charges are covered only as a result of accidental injury or for dependents only, check "not applicable."

___ Covered in full (usual + customary charges)
20

___ Covered subject to deductibles, coinsurance, and/or maximums
21

___ Covered under Basic Benefits
22

___ Covered under Major Medical
23

___ Other
24

___ Remarks
25

___ Not determinable
26

___ Not applicable (No vision care coverage) SKIP TO QUESTION 515.
27

___ Action code
28

If a Relative Value Schedule (RVS) is used to determine coverage of vision care procedures specified in questions 490-510, multiply the designated units by the conversion factor, code the product or dollar amount for that procedure when applicable, check "Remarks" and identify the conversion factor, name and base year of the RVS. If coverage of eyeglasses is subject to a schedule of benefits, check column 40 in question 490 and describe schedule in question 495.

490 Describe coverage of charges for eyeglasses.
1-3

___ No coverage of eyeglasses (SKIP TO QUESTION 500)
20

Covered:

___ Not subject to a separate maximum.
21

___ Subject to a $ _____ maximum payable separately.
22 23-25

___ Subject to an unspecified separate maximum.
26

___ Subject to a $ _____ maximum that also applies to eye examinations.
27 28-30

___ Subject to a $ _____ maximum that applies to all vision care
31 32-35

___ Subject to an unspecified maximum that also applies to eye examinations.
36

___ Other
37

___ Remarks
38

___ Not determinable
39

___ Not applicable (Subject to scheduled benefits)
40

___ Action code
41

495 Are charges for eyeglasses subject to a schedule? Check appropriate
1-3 space(s). Code for pair of lenses.

___ No
20

___ Yes
21

___ Single vision $ ___
22 23-25

___ Bifocal $ ___
26 27-29

___ Trifocal $ ___
30 31-33

___ Lenticular $ ___
34 35-37

___ Frames $ ___
38 39-41

___ Other
42

___ Remarks
43

___ Not determinable
44

___ Action code
45

500
1-3 Describe coverage of charges for eye examinations.

___
20 No coverage of eye examinations

Covered:

___
21 Not subject to a separate maximum.

___
22 Subject to a $ ___ (23-25) maximum payable separately.

___
26 Subject to an unspecified separate maximum.

___
27 Subject to a shared maximum with eyeglasses.

___
28 Subject to an overall maximum for vision care (see Question 490).

___
29 Other

___
30 Remarks

___
31 Not determinable

___
32 Not applicable

___
33 Action code

505
1-3 Describe coverage of charges for contact lenses.

___
20 No coverage of contact lenses.

Covered:

___
21 Not subject to a separate maximum.

___
22 Subject to a $ ______ maximum payable separately.
23-26

___
27 Subject to a $ ______ maximum for special conditions
28-31

(e.g., following cataract surgery) otherwise $ ______.
32-35

___
36 Subject to an unspecified separate maximum.

___
37 Covered in full, subject to special conditions (e.g., following cataract surgery); otherwise not covered.

___
38 Subject to an overall maximum for vision care (see Question 490).

___
39 Other

___
40 Remarks

___
41 Not determinable

___
42 Action code

510 Describe coverage of charges for orthoptics or visual training.
1-3

___ No coverage of orthoptics.
20

Covered:

___ Not subject to a separate maximum.
21

___ Subject to a $ ___ maximum payable separately.
22 23-25

___ Subject to an unspecified separate maximum.
26

___ Subject to an overall maximum for vision care
27 (see Question 490).

___ Other
28

___ Remarks
29

___ Not determinable
30

___ Not applicable
31

___ Action code
32

OTHER BENEFITS

515
1-3 Which of the following benefits are specifically included in this plan? Check appropriate spaces.

___ Second surgical opinion
20

___ Alcoholism treatment
21

___ Drug abuse treatment
22

___ Hearing care
23

___ Hospice care
24

___ Physical examinations
25

___ Remarks
26

___ Other
27

___ Not determinable
28

___ Not applicable (None of the above are included)
29

___ Action Code
30

520
1-3

Which of the following cost containment features are included in this plan? (Check appropriate spaces).

___ None
20

___ Incentive to seek second surgical opinion (check one):
21

  ___ Reduced payment for specified procedures if second opinion not obtained (higher payment is coded)
  22

  ___ Increased payment for specified procedures if second opinion is obtained (lower payment is coded)
  23

  ___ Increased payment for any procedure if second opinion is obtained (higher payment is coded)
  24

  ___ No payment for specified procedures if second opinion is not obtained
  25

___ Outpatient surgery covered more liberally than in-hospital surgery (check at least one)
26

  ___ Outpatient surgery covered at 100%
  27

  ___ Outpatient surgery not subject to deductible
  28

  ___ Outpatient surgery covered at 100% for specified procedures
  29

  ___ Other differences
  30

___ Generic drugs covered more liberally (coded for generic)
31

___ Weekend admissions to hospital covered differently (unless on an emergency basis)
32

___ Separate deductible (or waiting period) for hospital admissions
33

___ Preadmission testing
34

___ Ambulatory surgical center
35

___ Preadmission certification required
36

___ Birthing centers
37

___ Hospital audit program
38

Other
___
39

Remarks
___
40

Not determinable
___
41

Not applicable
___
42

Action code
___
43

SECTION C CODING INSTRUCTIONS

A) Unless otherwise specified, round percent to nearest whole percent and round dollar amounts to nearest whole dollar.

B) Section C questions are designed to identify and describe the benefit provisions of covered expenses in Section B that are subject to deductible, coinsurance, and/or maximum benefit provisions. This section consists of 15 sets of seven questions. One set of questions should be completed for each covered expense, or group of covered expenses that share a common description of their benefit provisions. In the first question of each set, the categories being described by the set of questions are checked. The remaining six questions give the benefit provisions for the categories checked in the first question. Additional sets of questions are completed until the benefit provisions of all covered expenses have been described.

1) Data that is already described in Section B need not be repeated in Section C.

2) None of the answers (a-f) should be left blank. If the specific answer is not applicable, check column 20.

3) In (b) we are not concerned with the length of the benefit period or the period of time within the deductible must be met; but rather wer are interested in how often the deductible must be met.

4) In (c) if the benefit has an "unlimited" maximum code up to $999999.

5) In answering (c), do not leave the "incurred expenses limit" (columns 25-30) blank. The coinsurance figure connot be coded by itself.

6) In answering (d), do not leave the "number of days" blank. The coinsurance figure cannot be coded by itself.

7) In answering (e), do not leave the "number of days" blank. The dollar value cannot be coded by itself.

8) If the deductible or benefit differs from accident and sickness, code for sickness and describe the deductible for an accident in Remarks.

9) Convert time worked by a private duty nurse as follows:

   a) 8 hour = 1 day
   b) 1 shift = 1 day

$\frac{600}{1-3}$ **Categories of covered expenses**

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
20	21	Hospital Room and Board (in-hospital)
22	23	Hospital Miscellaneous Charges (in-hospital)
24	25	Extended care (extended care facility)
26	27	Extended care (home health care)
28	29	
30	31	Surgical care (in-hospital, not charged by hospital)
32	33	Surgical care (outpatient department)
34	35	Surgical care (non-hospital)
36	37	
38	39	Medical care (in-hospital, not charged by hospital)
40	41	Medical care (office)
42	43	Diagnostic X-ray and Lab Testing (in-hospital)
44	45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
46	47	Diagnostic X-ray and Lab Testing (non-hospital)

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48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickne[illegible]
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

601
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ 62-63 month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ 90-92 % of earnings, with

$ ___ 93-96 maximum,

$ ___ 97-100 minimum

___ 101 $ ___ 102-104 for first ___ 105-107 days (or visits) and

$ ___ 108-110 for next ___ 111-113 days (or visits)

$ ___ 114-116 for next ___ 117-119 days (or visits)

___ 120 ___ 121-122 day deductible

___ Other
123

___ Remarks
124

___ Not determinable
125

___ Action code
126

602 c. Describe coinsurance by the amount of incurred expenses.
1-3

___ No application of coinsurance by amount of incurred expenses.
20

___ Plan pays _____ % for incurred expenses of $ _______ in excess
21 22-24 25-30

of basic benefits.

It then pays _____ % for an additional $ _______ of incurred expenses;
31-33 34-39

_____ % of next $ _______;
40-42 43-48

and _____ % in excess.
49-51

___ Plan pays _____ % for incurred expenses of $ _______ in excess
52 53-55 56-61

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays _____ % for an additional $ _______ of incurred expenses;
74-76 77-82

_____ % of next $ _______;
83-85 86-92

______ % in excess.
93-95

___ Plan pays _____ % for incurred expenses from $______
96 97-99 100-105

to $ ______;
106-111

______ % of next $ ______;
112-114 115-120

______ % of next $ ______;
121-123 124-129

______ % of excess
130-132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

603
1-3 d. Describe coinsurance by the number of days (or visits).

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

604 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.
1-3

___ No application of the maximum dollar amount by the number of days or visits.
20

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____ day (s);
74 75-78 79-82

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

Other
134

Remarks
135

Not determinable
136

Not applicable
137

Action code
138

605
1-3

f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

___ 20 No maximum number of days (or visits)

		Per Person Number of Days
___ 21	Per illness or confinement	___ 22-27
		___ 28-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ 56-58 month period	___ 59-64
___ 65	Per lifetime	___ 66-69

___ 70 Other

___ 71 Remarks

___ 72 Not determinable

___ 73 Not applicable

___ 74 Action code

606 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.
1-3

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per _____ (80-82) month	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

610 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
________ 20	________ 21	Hospital Room and Board (in-hospital)
________ 22	________ 23	Hospital Miscellaneous Charges (in-hospital)
________ 24	________ 25	Extended care (extended care facility)
________ 26	________ 27	Extended care (home health care)
________ 28	________ 29	
________ 30	________ 31	Surgical care (in-hospital, not charged by hospital)
________ 32	________ 33	Surgical care (outpatient department)
________ 34	________ 35	Surgical care (non-hospital)
________ 36	________ 37	
________ 38	________ 39	Medical care (in-hospital, not charged by hospital)
________ 40	________ 41	Medical care (office)
________ 42	________ 43	Diagnostic X-ray and Lab Testing (in-hospital)
________ 44	________ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
________ 46	________ 47	Diagnostic X-ray and Lab Testing (non-hospital)

48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

611
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

Per Person Per Family

___ No deductible
20

___ Per day (or visit) of $ ___.___
21 22-27

___ Per illness or confinement of$ ___.___
28 29-34

___ Deductible waived if expenses are incurred due to an accident
35

___ Per prescription $ ___.___
42 43-47

___ Per one year period of $ ___.___ or $ ___.___
48 49-54 55-60

___ Per ______ month period of $ ___.___ or $ ___.___
61 62-63 64-69 70-75

___ Per lifetime $ ___.___ or $ ___.___
76 77-82 83-88

___ ___.___ % of earnings, with
89 90-92

$ ______ maximum,
93-96

$ ______ minimum
97-100

___ $ ______ for first ______ days (or visits) and
101 102-104 105-107

$ ______ for next ______ days (or visits)
108-110 111-113

$ ______ for next ______ days (or visits)
114-116 117-119

___ ______ day deductible
120 121-122

Other
___
123

Remarks
___
124

Not determinable
___
125

Action code
___
126

612 c. Describe coinsurance by the amount of incurred expenses.
1-3

__ No application of coinsurance by amount of incurred expenses.
20

__ Plan pays ____ % for incurred expenses of $ ______ in excess of basic benefits.
21 22-24 25-30

It then pays ____ % for an additional $ ______ of incurred expenses;
31-33 34-39

____ % of next $ ______;
40-42 43-48

and ____ % in excess.
49-51

__ Plan pays ____ % for incurred expenses of $ ______ in excess
52 53-55 56-61

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays ____ % for an additional $ ______ of incurred expenses;
74-76 77-82

____ % of next $ ______;
83-85 86-92

______ % in excess.
93-95

___ Plan pays ______ % for incurred expenses from $______
96 97-99 100-105

to $ ______;
106-111

______ % of next $ ______;
112-114 115-120

______ % of next $ ______;
121-123 124-129

______ % of excess
130-132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

613 d. Describe coinsurance by the number of days (or visits).
1-3

____ No application of coinsurance by number of days (or visits).
20

____ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

____ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

____ Other
98

____ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

614
1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

__ No application of the maximum dollar amount by the number
20 of days or visits.

__ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

__ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ ______ per day for the next ______ day (s);
99-102 103-106

$ _______ per day for the next _______ day (s);
107-110 111-114

$ _______ per day for the next _______ day (s);
115-118 119-122

$ _______ per day for the next $ _______ of incurred expenses.
123-126 127-133

___ Other
134

___ Remarks
135

___ Not determinable
136

___ Not applicable
137

___ Action code
138

615
1-3 f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

___ 20	No maximum number of days (or visits)	
		Per Person Number of Days
___ 21	Per illness or confinement	___ 22-27
		___ 28-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ (56-58) month period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

616
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

______
22-26

Per Person
Dollar
amount

___ Per day (or visit) $______
27 28-32

___ Per six month period $______
33 34-40

___ Per illness or confinement $______
41 42-49

___ Per lifetime $______
50 51-60

___ Per one year period $______
61 62-69

___ Per two year period $______
70 71-78

___ Per ______ month $______
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

620 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

____ 48	____ 49	
____ 50	____ 51	Prescription Drugs (non-hospital)
____ 52	____ 53	Private Duty Nursing (in-hospital)
____ 54	____ 55	Private Duty Nursing (non-hospital)
____ 56	____ 57	
____ 58	____ 59	Mental Health Care (in-hospital)
____ 60	____ 61	Mental Health Care (in-hospital, not charged by hospital)
____ 62	____ 63	Mental Health Care (outpatient department)
____ 64	____ 65	Mental Health Care (non-hospital)
____ 66	____ 67	
____ 68	____ 69	Dental Care
____ 70	____ 71	Vision Care
____ 72	____ 73	Outpatient Care (accident and/or emergency sickness)
__ 74		Other
__ 75		Remarks
__ 76		Not determinable
__ 77		Not applicable
__ 78		Action code

621
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ______ (62-63) month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ____.__ (90-92) % of earnings, with

$ ______ (93-96) maximum,

$ ______ (97-100) minimum

___ 101 $ ______ (102-104) for first ______ (105-107) days (or visits) and

$ ______ (108-110) for next ______ (111-113) days (or visits)

$ ______ (114-116) for next ______ (117-119) days (or visits)

___ 120 ______ (121-122) day deductible

Other
123

Remarks
124

Not determinable
125

Action code
126

622
1-3
c. Describe coinsurance by the amount of incurred expenses.

____
20
No application of coinsurance by amount of incurred expenses.

____
21
Plan pays ____ 22-24 % for incurred expenses of $ ____ 25-30 in excess of basic benefits.

It then pays ____ 31-33 % for an additional $ ____ 34-39 of incurred expenses;

____ 40-42 % of next $ ____ 43-48;

and ____ 49-51 % in excess.

____
52
Plan pays ____ 53-65 % for incurred expenses of $ ____ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays ____ 74-76 % for an additional $ ____ 77-82 of incurred expenses;

____ 83-~~95~~85 % of next $ ____ 86-~~102~~92;

____ 93-95 % in excess.

____ 96 Plan pays ____ 97-99 % for incurred expenses from $____ 100-105

to $ ____ 106-111;

____ 112-114 % of next $ ____ 115-120;

____ 121-123 % of next $ ____ 124-129;

____ 130-~~162~~ 132 % of excess

____ 133 Other

____ 134 Remarks

____ 135 Not determinable

____ 136 Not applicable

____ 137 Action code

623
1-3
d. Describe coinsurance by the number of days (or visits).

___ 20 No application of coinsurance by number of days (or visits).

___ 21 Plan pays _____ 22-24 % of usual, reasonable, or customary charges

between _____ 25-27 day and _____ 28-30 day(s); then pays;

_____ 31-33 % for next _____ 34-37 day (s);

_____ 38-40 % for next _____ 41-44 day (s);

_____ 45-47 % for next _____ 48-51 day (s);

_____ 52-54 % thereafter.

___ 55 Plan pays _____ 56-58 % of usual, reasonable, or customary charges

between _____ 59-62 day and _____ 63-66 day(s); then pays;

_____ 67-69 % for next _____ 70-73 day (s);

_____ 74-76 % for next _____ 77-80 day (s);

_____ 81-83 % for next _____ 84-87 day (s);

_____ 88-90 % for next $ _____ 91-97 of incurred expenses.

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

624
1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

___ Other
134

___ Remarks
135

___ Not determinable
136

___ Not applicable
137

___ Action code
138

625/1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ 20 No dollar maximum pertaining to this section

___ 21 Unlimited dollar maximum

		Per Person Dollar amount
___ 27	Per day (or visit)	$___ 28-32
___ 33	Per six month period	$___ 34-40
___ 41	Per illness or confinement	$___ 42-49
___ 50	Per lifetime	$___ 51-60
___ 61	Per one year period	$___ 62-69
___ 70	Per two year period	$___ 71-78
___ 79	Per ___ 80-82 month	$___ 83-91

___ 92 Other

___ 93 Remarks

___ 94 Not determinable

___ 95 Not applicable

___ 96 Action code

626
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per _____ (80-82) month	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

630
1-3

Categories of covered expenses

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
20	21	Hospital Room and Board (in-hospital)
22	23	Hospital Miscellaneous Charges (in-hospital)
24	25	Extended care (extended care facility)
26	27	Extended care (home health care)
28	29	
30	31	Surgical care (in-hospital, not charged by hospital)
32	33	Surgical care (outpatient department)
34	35	Surgical care (non-hospital)
36	37	
38	39	Medical care (in-hospital, not charged by hospital)
40	41	Medical care (office)
42	43	Diagnostic X-ray and Lab Testing (in-hospital)
44	45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
46	47	Diagnostic X-ray and Lab Testing (non-hospital)

48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

631
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

Per Person   Per Family

___ No deductible
20

___ Per day (or visit) of $ ___.___
21 22-27

___ Per illness or confinement of $ ___.___
28 29-34

___ Deductible waived if expenses are incurred due to an accident
35

______
36-41

___ Per prescription $ ___.___
42 43-47

___ Per one year period of $ ___.___ or $ ___.___
48 49-54 55-60

___ Per ______ month period of $ ___.___ or $ ___.___
61 62-63 64-69 70-75

___ Per lifetime $ ___.___ or $ ___.___
76 77-82 83-88

___ ____.__ % of earnings, with
89 90-92

$ ______ maximum,
93-96

$ ______ minimum
97-100

___ $ ______ for first ______ days (or visits) and
101 102-104 105-107

$ ______ for next ______ days (or visits)
108-110 111-113

$ ______ for next ______ days (or visits)
114-116 117-119

___ ______ day deductible
120 121-122

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

632
1-3 c. Describe coinsurance by the amount of incurred expenses.

___ 20 No application of coinsurance by amount of incurred expenses.

___ 21 Plan pays _____ 22-24 % for incurred expenses of $ _______ 25-30 in excess of basic benefits.

It then pays _____ 31-33 % for an additional $ _______ 34-39 of incurred expenses;

_____ 40-42 % of next $ _______ 43-48;

and _____ 49-51 % in excess.

___ 52 Plan pays _____ 53-65 % for incurred expenses of $ _______ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays _____ 74-76 % for an additional $ _______ 77-82 of incurred expenses;

_____ 83-~~95~~85 % of next $ _______ 86-~~102~~92;

_____ 93-95 % in excess.

___ Plan pays _____ % for incurred expenses from $_______
96 97-99 100-105

to $ _______;
106-111

_______ % of next $ _______;
112-114 115-120

_______ % of next $ _______;
121-123 124-129

_______ % of excess
130-~~162~~ 132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

633 d. Describe coinsurance by the number of days (or visits).
1-3

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

634 e. Describe the application of the maximum dollar amount per day or visit
1-3 by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

___ Other
134

___ Remarks
135

___ Not determinable
136

___ Not applicable
137

___ Action code
138

635
1-3 f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

___ 20 No maximum number of days (or visits)

		Per Person Number of Days
___ 21	Per illness or confinement	___ 22-27
___ 28	Per pregnancy	___ 29-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ 56-58 month period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

636
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per _____ month 80-82	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

640
1-3 Categories of covered expenses

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

______ 48	______ 49	
______ 50	______ 51	Prescription Drugs (non-hospital)
______ 52	______ 53	Private Duty Nursing (in-hospital)
______ 54	______ 55	Private Duty Nursing (non-hospital)
______ 56	______ 57	
______ 58	______ 59	Mental Health Care (in-hospital)
______ 60	______ 61	Mental Health Care (in-hospital, not charged by hospital)
______ 62	______ 63	Mental Health Care (outpatient department)
______ 64	______ 65	Mental Health Care (non-hospital)
______ 66	______ 67	
______ 68	______ 69	Dental Care
______ 70	______ 71	Vision Care
______ 72	______ 73	Outpatient Care (accident and/or emergency sickness)
__ 74		Other
__ 75		Remarks
__ 76		Not determinable
__ 77		Not applicable
__ 78		Action code

641/1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ 62-63 month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ 90-92 % of earnings, with

$ ___ 93-96 maximum,

$ ___ 97-100 minimum

___ 101 $ ___ 102-104 for first ___ 105-107 days (or visits) and

$ ___ 108-110 for next ___ 111-113 days (or visits)

$ ___ 114-116 for next ___ 117-119 days (or visits)

___ 120 ___ 121-122 day deductible

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

642
1-3 c. Describe coinsurance by the amount of incurred expenses.

___
20 No application of coinsurance by amount of incurred expenses.

___
21 Plan pays _____ % for incurred expenses of $ _______ in excess
22-24 25-30

of basic benefits.

It then pays _____ % for an additional $ _______ of incurred expenses;
31-33 34-39

_____ % of next $ _______;
40-42 43-48

and _____ % in excess.
49-51

___
52 Plan pays _____ % for incurred expenses of $ _______ in excess
53-65 56-71

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays _____ % for an additional $ _______ of incurred expenses;
74-76 77-82

_____ % of next $ _______;
83-~~95~~85 86-~~102~~92

_____ % in excess.
93-95

____ Plan pays _____ % for incurred expenses from $______
96 97-99 100-105

to $ ______;
106-111

______ % of next $ ______;
112-114 115-120

______ % of next $ ______;
121-123 124-129

______ % of excess
130-~~162~~ 132

____ Other
133

____ Remarks
134

____ Not determinable
135

____ Not applicable
136

____ Action code
137

643/1-3 d. Describe coinsurance by the number of days (or visits).

___ 20 No application of coinsurance by number of days (or visits).

___ 21 Plan pays _____ 22-24 % of usual, reasonable, or customary charges

between _____ 25-27 day and _____ 28-30 day(s); then pays;

_____ 31-33 % for next _____ 34-37 day (s);

_____ 38-40 % for next _____ 41-44 day (s);

_____ 45-47 % for next _____ 48-51 day (s);

_____ 52-54 % thereafter.

___ 55 Plan pays _____ 56-58 % of usual, reasonable, or customary charges

between _____ 59-62 day and _____ 63-66 day(s); then pays;

_____ 67-69 % for next _____ 70-73 day (s);

_____ 74-76 % for next _____ 77-80 day (s);

_____ 81-83 % for next _____ 84-87 day (s);

_____ 88-90 % for next $ _____ 91-97 of incurred expenses.

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

644
1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

___ 20 No application of the maximum dollar amount by the number of days or visits.

___ 21 Maximum $ _____ 22-25 per day (or visit) for the first _____ 26-29 day(s);

$ _____ 30-33 per day for the next _____ 34-37 day (s);

$ _____ 38-41 per day for the next _____ 42-45 day (s);

$ _____ 46-49 per day for the next _____ 50-53 day (s);

$ _____ 54-57 per day for the next _____ 58-61 day (s);

$ _____ 62-65 per day for the next _____ 66-69 day (s);

$ _____ 70-73 thereafter.

___ 74 Maximum $ _____ 75-78 per day (or visit) for the first _____ 79-82 day (s);

$ _____ 83-86 per day for the next _____ 87-90 day (s);

$ _____ 91-94 per day for the next _____ 95-98 day (s);

$ _____ 99-102 per day for the next _____ 103-106 day (s);

$ _____ 107-110 per day for the next _____ 111-114 day (s);

$ _____ 115-118 per day for the next _____ 119-122 day (s);

$ _____ 123-126 per day for the next $ _____ 127-133 of incurred expenses.

___ **Other**
134

___ **Remarks**
135

___ **Not determinable**
136

___ **Not applicable**
137

___ **Action code**
138

645
1-3 f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

___ 20 No maximum number of days (or visits)

		Per Person Number of Days
___ 21	Per illness or confinement	___ 22-27
___ 28	Per pregnancy	___ 29-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ 56-58 month period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

646 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.
1-3

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

Per Person
Dollar
amount

___ Per day (or visit) $_____
27 28-32

___ Per six month $_____
33 period 34-40

___ Per illness or $_____
41 confinement 42-49

___ Per lifetime $_____
50 51-60

___ Per one year $_____
61 period 62-69

___ Per two year $_____
70 period 71-78

___ Per _____ month $_____
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

650
1-3 **Categories of covered expenses**

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
____ 20	____ 21	Hospital Room and Board (in-hospital)
____ 22	____ 23	Hospital Miscellaneous Charges (in-hospital)
____ 24	____ 25	Extended care (extended care facility)
____ 26	____ 27	Extended care (home health care)
____ 28	____ 29	
____ 30	____ 31	Surgical care (in-hospital, not charged by hospital)
____ 32	____ 33	Surgical care (outpatient department)
____ 34	____ 35	Surgical care (non-hospital)
____ 36	____ 37	
____ 38	____ 39	Medical care (in-hospital, not charged by hospital)
____ 40	____ 41	Medical care (office)
____ 42	____ 43	Diagnostic X-ray and Lab Testing (in-hospital)
____ 44	____ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
____ 46	____ 47	Diagnostic X-ray and Lab Testing (non-hospital)

48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

651 b. Describe the deductible applied to the specified categories of
1-3 expenses. Check appropriate spaces and enter the dollar and cent amount.

Per Person **Per Family**

___ No deductible
20

___ Per day (or visit) of $ ___.___
21 22-27

___ Per illness or confinement of $ ___.___
28 29-34

___ Deductible waived if expenses are incurred due to an accident
35

______
36-41

___ Per prescription $ ___.___
42 43-47

___ Per one year period of $ ___.___ or $ ___.___
48 49-54 55-60

___ Per _____ month period of $ ___.___ or $ ___.___
61 62-63 64-69 70-75

___ Per lifetime $ ___.___ or $ ___.___
76 77-82 83-88

___ ____.__ % of earnings, with
89 90-92

$ _____ maximum,
93-96

$ _____ minimum
97-100

___ $ ______ for first ______ days (or visits) and
101 102-104 105-107

$ ______ for next ______ days (or visits)
108-110 111-113

$ ______ for next ______ days (or visits)
114-116 117-119

___ ______ day deductible
120 121-122

___ Other
123

___ Remarks
124

___ Not determinable
125

___ Action code
126

652
1-3 c. Describe coinsurance by the amount of incurred expenses.

___ No application of coinsurance by amount of incurred expenses.
20

___ Plan pays _____ % for incurred expenses of $ ______ in excess
21 22-24 25-30

of basic benefits.

It then pays _____ % for an additional $ ______ of incurred expenses;
31-33 34-39

_____ % of next $ ______;
40-42 43-48

and _____ % in excess.
49-51

___ Plan pays _____ % for incurred expenses of $ ______ in excess
52 53-65 56-71

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays _____ % for an additional $ ______ of incurred expenses;
74-76 77-82

_____ % of next $ ______;
83-~~95~~85 86-~~102~~92

_____ % in excess.
93-95

___ Plan pays _____ % for incurred expenses from $______
96 97-99 100-105

to $ _______;
106-111

_______ % of next $ _______;
112-114 115-120

_______ % of next $ _______;
121-123 124-129

_______ % of excess
130-~~162~~ 132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

653 d. Describe coinsurance by the number of days (or visits).
1-3

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

654 e. Describe the application of the maximum dollar amount per day or visit
1-3 by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

______ Other
134

______ Remarks
135

______ Not determinable
136

______ Not applicable
137

______ Action code
138

655
1-3

f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

		Per Person Number of Days
___ 20	No maximum number of days (or visits)	
___ 21	Per illness or confinement	___ 22-27
___ 28	Per pregnancy	___ 29-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ month 56-58 period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

656
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

______
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per ______ month 80-82	$_____ 83-91
___ 92	Other	
___ 93	Remarks	
___ 94	Not determinable	
___ 95	Not applicable	
___ 96	Action code	

660 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
____ 20	____ 21	Hospital Room and Board (in-hospital)
____ 22	____ 23	Hospital Miscellaneous Charges (in-hospital)
____ 24	____ 25	Extended care (extended care facility)
____ 26	____ 27	Extended care (home health care)
____ 28	____ 29	
____ 30	____ 31	Surgical care (in-hospital, not charged by hospital)
____ 32	____ 33	Surgical care (outpatient department)
____ 34	____ 35	Surgical care (non-hospital)
____ 36	____ 37	
____ 38	____ 39	Medical care (in-hospital, not charged by hospital)
____ 40	____ 41	Medical care (office)
____ 42	____ 43	Diagnostic X-ray and Lab Testing (in-hospital)
____ 44	____ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
____ 46	____ 47	Diagnostic X-ray and Lab Testing (non-hospital)

____ 48	____ 49	
____ 50	____ 51	Prescription Drugs (non-hospital)
____ 52	____ 53	Private Duty Nursing (in-hospital)
____ 54	____ 55	Private Duty Nursing (non-hospital)
____ 56	____ 57	
____ 58	____ 59	Mental Health Care (in-hospital)
____ 60	____ 61	Mental Health Care (in-hospital, not charged by hospital)
____ 62	____ 63	Mental Health Care (outpatient department)
____ 64	____ 65	Mental Health Care (non-hospital)
____ 66	____ 67	
____ 68	____ 69	Dental Care
____ 70	____ 71	Vision Care
____ 72	____ 73	Outpatient Care (accident and/or emergency sickness)
__ 74		Other
__ 75		Remarks
__ 76		Not determinable
__ 77		Not applicable
__ 78		Action code

661 b. Describe the deductible applied to the specified categories of
1-3 expenses. Check appropriate spaces and enter the dollar and cent amount.

Per Person Per Family

___ No deductible
20

___ Per day (or visit) of $ ___.___
21 22-27

___ Per illness or confinement of $ ___.___
28 29-34

___ Deductible waived if expenses are incurred due to an accident
35

______
36-41

___ Per prescription $ ___.___
42 43-47

___ Per one year period of $ ___.___ or $ ___.___
48 49-54 55-60

___ Per ___ month period of $ ___.___ or $ ___.___
61 62-63 64-69 70-75

___ Per lifetime $ ___.___ or $ ___.___
76 77-82 83-88

___ ___.___ % of earnings, with
89 90-92

$ ______ maximum,
93-96

$ ______ minimum
97-100

___ $ ______ for first ______ days (or visits) and
101 102-104 105-107

$ ______ for next ______ days (or visits)
108-110 111-113

$ ______ for next ______ days (or visits)
114-116 117-119

___ ______ day deductible
120 121-122

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

662
1-3

c. Describe coinsurance by the amount of incurred expenses.

___
20
No application of coinsurance by amount of incurred expenses.

___
21
Plan pays _____ 22-24 % for incurred expenses of $ _______ 25-30 in excess of basic benefits.

It then pays _____ 31-33 % for an additional $ _______ 34-39 of incurred expenses;

_____ 40-42 % of next $ _______ 43-48;

and _____ 49-51 % in excess.

___
52
Plan pays _____ 53-65 % for incurred expenses of $ _______ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays _____ 74-76 % for an additional $ _______ 77-82 of incurred expenses;

_____ 83-~~95~~85 % of next $ _______ 86-~~102~~92;

_____ 93-95 % in excess.

___ 96 Plan pays ___ 97-99 % for incurred expenses from $ ___ 100-105

to $ ___ 106-111;

___ 112-114 % of next $ ___ 115-120;

___ 121-123 % of next $ ___ 124-129;

___ 130-~~162~~132 % of excess

___ 133 Other

___ 134 Remarks

___ 135 Not determinable

___ 136 Not applicable

___ 137 Action code

$\underset{1-3}{\underline{663}}$ d. Describe coinsurance by the number of days (or visits).

$\underset{20}{\underline{\qquad}}$ No application of coinsurance by number of days (or visits).

$\underset{21}{\underline{\qquad}}$ Plan pays $\underset{22-24}{\underline{\qquad}}$ % of usual, reasonable, or customary charges

between $\underset{25-27}{\underline{\qquad}}$ day and $\underset{28-30}{\underline{\qquad}}$ day(s); then pays;

$\underset{31-33}{\underline{\qquad}}$ % for next $\underset{34-37}{\underline{\qquad}}$ day (s);

$\underset{38-40}{\underline{\qquad}}$ % for next $\underset{41-44}{\underline{\qquad}}$ day (s);

$\underset{45-47}{\underline{\qquad}}$ % for next $\underset{48-51}{\underline{\qquad}}$ day (s);

$\underset{52-54}{\underline{\qquad}}$ % thereafter.

$\underset{55}{\underline{\qquad}}$ Plan pays $\underset{56-58}{\underline{\qquad}}$ % of usual, reasonable, or customary charges

between $\underset{59-62}{\underline{\qquad}}$ day and $\underset{63-66}{\underline{\qquad}}$ day(s); then pays;

$\underset{67-69}{\underline{\qquad}}$ % for next $\underset{70-73}{\underline{\qquad}}$ day (s);

$\underset{74-76}{\underline{\qquad}}$ % for next $\underset{77-80}{\underline{\qquad}}$ day (s);

$\underset{81-83}{\underline{\qquad}}$ % for next $\underset{84-87}{\underline{\qquad}}$ day (s);

$\underset{88-90}{\underline{\qquad}}$ % for next \$ $\underset{91-97}{\underline{\qquad}}$ of incurred expenses.

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

664 1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

___ 20 No application of the maximum dollar amount by the number of days or visits.

___ 21 Maximum $ _____ 22-25 per day (or visit) for the first _____ 26-29 day(s);

$ _____ 30-33 per day for the next _____ 34-37 day (s);

$ _____ 38-41 per day for the next _____ 42-45 day (s);

$ _____ 46-49 per day for the next _____ 50-53 day (s);

$ _____ 54-57 per day for the next _____ 58-61 day (s);

$ _____ 62-65 per day for the next _____ 66-69 day (s);

$ _____ 70-73 thereafter.

___ 74 Maximum $ _____ 75-78 per day (or visit) for the first _____ 79-82 day (s);

$ _____ 83-86 per day for the next _____ 87-90 day (s);

$ _____ 91-94 per day for the next _____ 95-98 day (s);

$ _____ 99-102 per day for the next _____ 103-106 day (s);

$ _____ 107-110 per day for the next _____ 111-114 day (s);

$ _____ 115-118 per day for the next _____ 119-122 day (s);

$ _____ 123-126 per day for the next $ _____ 127-133 of incurred expenses.

Other
___
134

Remarks
___
135

Not determinable
___
136

Not applicable
___
137

Action code
___
138

665 1-3 f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

		Per Person Number of Days
___ 20	No maximum number of days (or visits)	
___ 21	Per illness or confinement	___ 22-27
___ 28	Per pregnancy	___ 29-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ 56-58 month period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

666 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.
1-3

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

______ 22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per ______ (80-82) month	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

670
1-3 Categories of covered expenses

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

____ 48	____ 49	
____ 50	____ 51	Prescription Drugs (non-hospital)
____ 52	____ 53	Private Duty Nursing (in-hospital)
____ 54	____ 55	Private Duty Nursing (non-hospital)
____ 56	____ 57	
____ 58	____ 59	Mental Health Care (in-hospital)
____ 60	____ 61	Mental Health Care (in-hospital, not charged by hospital)
____ 62	____ 63	Mental Health Care (outpatient department)
____ 64	____ 65	Mental Health Care (non-hospital)
____ 66	____ 67	
____ 68	____ 69	Dental Care
____ 70	____ 71	Vision Care
____ 72	____ 73	Outpatient Care (accident and/or emergency sickness)
____ 74		Other
____ 75		Remarks
____ 76		Not determinable
____ 77		Not applicable
____ 78		Action code

671
1-3

b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ (62-63) month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ 90-92 % of earnings, with

$ ___ 93-96 maximum,

$ ___ 97-100 minimum

___ 101 $ ___ 102-104 for first ___ 105-107 days (or visits) and

$ ___ 108-110 for next ___ 111-113 days (or visits)

$ ___ 114-116 for next ___ 117-119 days (or visits)

___ 120 ___ 121-122 day deductible

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

672
1-3
c. Describe coinsurance by the amount of incurred expenses.

___ No application of coinsurance by amount of incurred expenses.
20

___ Plan pays _____ % for incurred expenses of $ _______ in excess
21 22-24 25-30

of basic benefits.

It then pays _____ % for an additional $ _______ of incurred expenses;
31-33 34-39

_____ % of next $ _______;
40-42 43-48

and _____ % in excess.
49-51

___ Plan pays _____ % for incurred expenses of $ _______ in excess
52 53-65 56-71

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays _____ % for an additional $ _______ of incurred expenses;
74-76 77-82

_____ % of next $ _______;
83-~~95~~85 86-~~102~~92

_____ % in excess.
93-95

___ 96 Plan pays _____ 97-99 % for incurred expenses from $ ______ 100-105

to $ ______ 106-111;

______ 112-114 % of next $ ______ 115-120;

______ 121-123 % of next $ ______ 124-129;

______ 130-~~162~~ 132 % of excess

___ 133 Other

___ 134 Remarks

___ 135 Not determinable

___ 136 Not applicable

___ 137 Action code

673 d. Describe coinsurance by the number of days (or visits).
1-3

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

674 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.
1-3

___ No application of the maximum dollar amount by the number of days or visits.
20

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

Other
134

Remarks
135

Not determinable
136

Not applicable
137

Action code
138

675
1-3

f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

___ No maximum number of days (or visits)
20

		Per Person Number of Days
___ 21	Per illness or confinement	___ 22-27
___ 28	Per pregnancy	___ 29-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ (56-58) month period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

676
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

______
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per ______ month 80-82	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

680 **Categories of covered expenses**
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

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48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

681
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ 62-63 month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ 90-92 % of earnings, with

$ ___ 93-96 maximum,

$ ___ 97-100 minimum

___ 101 $ ___ 102-104 for first ___ 105-107 days (or visits) and

$ ___ 108-110 for next ___ 111-113 days (or visits)

$ ___ 114-116 for next ___ 117-119 days (or visits)

___ 120 ___ 121-122 day deductible

___ Other
123

___ Remarks
124

___ Not determinable
125

___ Action code
126

682
1-3 c. Describe coinsurance by the amount of incurred expenses.

___ 20 No application of coinsurance by amount of incurred expenses.

___ 21 Plan pays _____ 22-24 % for incurred expenses of $ _______ 25-30 in excess of basic benefits.

It then pays _____ 31-33 % for an additional $ _______ 34-39 of incurred expenses;

_____ 40-42 % of next $ _______ 43-48;

and _____ 49-51 % in excess.

___ 52 Plan pays _____ 53-65 % for incurred expenses of $ _______ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays _____ 74-76 % for an additional $ _______ 77-82 of incurred expenses;

_____ 83-~~95~~85 % of next $ _______ 86-~~102~~92;

_____ 93-95 % in excess.

____ Plan pays _____ % for incurred expenses from $_______
96 97-99 100-105

to $ _______;
106-111

_______ % of next $ _______;
112-114 115-120

_______ % of next $ _______;
121-123 124-129

_______ % of excess
130-~~162~~
132

____ Other
133

____ Remarks
134

____ Not determinable
135

____ Not applicable
136

____ Action code
137

683
1-3
d. Describe coinsurance by the number of days (or visits).

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

684
1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

___ 20 No application of the maximum dollar amount by the number of days or visits.

___ 21 Maximum $ _____ 22-25 per day (or visit) for the first _____ 26-29 day(s);

$ _____ 30-33 per day for the next _____ 34-37 day (s);

$ _____ 38-41 per day for the next _____ 42-45 day (s);

$ _____ 46-49 per day for the next _____ 50-53 day (s);

$ _____ 54-57 per day for the next _____ 58-61 day (s);

$ _____ 62-65 per day for the next _____ 66-69 day (s);

$ _____ 70-73 thereafter.

___ 74 Maximum $ _____ 75-78 per day (or visit) for the first _____ 79-82 day (s);

$ _____ 83-86 per day for the next _____ 87-90 day (s);

$ _____ 91-94 per day for the next _____ 95-98 day (s);

$ _____ 99-102 per day for the next _____ 103-106 day (s);

$ _____ 107-110 per day for the next _____ 111-114 day (s);

$ _____ 115-118 per day for the next _____ 119-122 day (s);

$ _____ 123-126 per day for the next $ _____ 127-133 of incurred expenses.

Other
134

Remarks
135

Not determinable
136

Not applicable
137

Action code
138

685
1-3 f. Describe the maximum number of days (or visits) for the specified covered expenses. Check appropriate spaces and enter the number of days (or visits).

___ 20 No maximum number of days (or visits)

		Per Person Number of Days
___ 21	Per illness or confinement	___ 22-27
___ 28	Per pregnancy	___ 29-33
___ 34	Per six month period	___ 35-40
___ 41	Per one year period	___ 42-47
___ 48	Per two year period	___ 49-54
___ 55	Per ___ 56-58 month period	___ 59-64
___ 65	Per lifetime	___ 66-69
___ 70	Other	
___ 71	Remarks	
___ 72	Not determinable	
___ 73	Not applicable	
___ 74	Action code	

686
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

Per Person
Dollar
amount

___ Per day (or visit) $_____
27 28-32

___ Per six month period $_____
33 34-40

___ Per illness or confinement $_____
41 42-49

___ Per lifetime $_____
50 51-60

___ Per one year period $_____
61 62-69

___ Per two year period $_____
70 71-78

___ Per ______ month $_____
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

690 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

______ 48	______ 49	
______ 50	______ 51	Prescription Drugs (non-hospital)
______ 52	______ 53	Private Duty Nursing (in-hospital)
______ 54	______ 55	Private Duty Nursing (non-hospital)
______ 56	______ 57	
______ 58	______ 59	Mental Health Care (in-hospital)
______ 60	______ 61	Mental Health Care (in-hospital, not charged by hospital)
______ 62	______ 63	Mental Health Care (outpatient department)
______ 64	______ 65	Mental Health Care (non-hospital)
______ 66	______ 67	
______ 68	______ 69	Dental Care
______ 70	______ 71	Vision Care
______ 72	______ 73	Outpatient Care (accident and/or emergency sickness)
__ 74		Other
__ 75		Remarks
__ 76		Not determinable
__ 77		Not applicable
__ 78		Action code

691
1-3

b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

Per Person   Per Family

___ No deductible
20

___ Per day (or visit) of $ ___.___
21   22-27

___ Per illness or confinement of $ ___.___
28   29-34

___ Deductible waived if expenses are incurred due to an accident
35

______
36-41

___ Per prescription $ ___.___
42   43-47

___ Per one year period of $ ___.___ or $ ___.___
48   49-54   55-60

___ Per ______ month period of $ ___.___ or $ ___.___
61   62-63   64-69   70-75

___ Per lifetime $ ___.___ or $ ___.___
76   77-82   83-88

___ ___.__ % of earnings, with
89   90-92

$ ______ maximum,
93-96

$ ______ minimum
97-100

___ $ ______ for first ______ days (or visits) and
101   102-104   105-107

$ ______ for next ______ days (or visits)
108-110   111-113

$ ______ for next ______ days (or visits)
114-116   117-119

___ ______ day deductible
120   121-122

____ Other
123

____ Remarks
124

____ Not determinable
125

____ Action code
126

692
1-3

c. Describe coinsurance by the amount of incurred expenses.

___
20
No application of coinsurance by amount of incurred expenses.

___
21
Plan pays _____ 22-24 % for incurred expenses of $ _______ 25-30 in excess of basic benefits.

It then pays _____ 31-33 % for an additional $ _______ 34-39 of incurred expenses;

_____ 40-42 % of next $ _______ 43-48;

and _____ 49-51 % in excess.

___
52
Plan pays _____ 53-65 % for incurred expenses of $ _______ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays _____ 74-76 % for an additional $ _______ 77-82 of incurred expenses;

_____ 83-~~95~~85 % of next $ _______ 86-~~102~~92;

_____ 93-95 % in excess.

96 Plan pays 97-99 % for incurred expenses from $ 100-105

to $ 106-111;

112-114 % of next $ 115-120;

121-123 % of next $ 124-129;

130-~~162~~ 132 % of excess

133 Other

134 Remarks

135 Not determinable

136 Not applicable

137 Action code

693 d. Describe coinsurance by the number of days (or visits).
1-3

____ No application of coinsurance by number of days (or visits).
20

____ Plan pays ____ % of usual, reasonable, or customary charges
21 22-24

between ____ day and ____ day(s); then pays;
25-27 28-30

____ % for next ____ day (s);
31-33 34-37

____ % for next ____ day (s);
38-40 41-44

____ % for next ____ day (s);
45-47 48-51

____ % thereafter.
52-54

____ Plan pays ____ % of usual, reasonable, or customary charges
55 56-58

between ____ day and ____ day(s); then pays;
59-62 63-66

____ % for next ____ day (s);
67-69 70-73

____ % for next ____ day (s);
74-76 77-80

____ % for next ____ day (s);
81-83 84-87

____ % for next $ ____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

694 e. Describe the application of the maximum dollar amount per day or visit
1-3 by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

____ Other
134

____ Remarks
135

____ Not determinable
136

____ Not applicable
137

____ Action code
138

695 g. Describe the maximum dollar amount payable for the specified categories
1-3 of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

Per Person
Dollar
amount

___ Per day (or visit) $___
27 28-32

___ Per six month period $___
33 34-40

___ Per illness or confinement $___
41 42-49

___ Per lifetime $___
50 51-60

___ Per one year period $___
61 62-69

___ Per two year period $___
70 71-78

___ Per ___ month $___
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

696
1-3

g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per _____ month 80-82	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

$\frac{700}{1-3}$ Categories of covered expenses

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
________ 20	________ 21	Hospital Room and Board (in-hospital)
________ 22	________ 23	Hospital Miscellaneous Charges (in-hospital)
________ 24	________ 25	Extended care (extended care facility)
________ 26	________ 27	Extended care (home health care)
________ 28	________ 29	
________ 30	________ 31	Surgical care (in-hospital, not charged by hospital)
________ 32	________ 33	Surgical care (outpatient department)
________ 34	________ 35	Surgical care (non-hospital)
________ 36	________ 37	
________ 38	________ 39	Medical care (in-hospital, not charged by hospital)
________ 40	________ 41	Medical care (office)
________ 42	________ 43	Diagnostic X-ray and Lab Testing (in-hospital)
________ 44	________ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
________ 46	________ 47	Diagnostic X-ray and Lab Testing (non-hospital)

48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

701 1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ 62-63 month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ 90-92 % of earnings, with

$ ___ 93-96 maximum,

$ ___ 97-100 minimum

___ 101 $ ___ 102-104 for first ___ 105-107 days (or visits) and

$ ___ 108-110 for next ___ 111-113 days (or visits)

$ ___ 114-116 for next ___ 117-119 days (or visits)

___ 120 ___ 121-122 day deductible

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

702
1-3 c. Describe coinsurance by the amount of incurred expenses.

____ 20 No application of coinsurance by amount of incurred expenses.

____ 21 Plan pays ____ 22-24 % for incurred expenses of $ ____ 25-30 in excess of basic benefits.

It then pays ____ 31-33 % for an additional $ ____ 34-39 of incurred expenses;

____ 40-42 % of next $ ____ 43-48;

and ____ 49-51 % in excess.

____ 52 Plan pays ____ 53-65 % for incurred expenses of $ ____ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays ____ 74-76 % for an additional $ ____ 77-82 of incurred expenses;

____ 83-~~95~~ 85 % of next $ ____ 86-~~102~~ 92;

____ 93-95 % in excess.

___ Plan pays _____ % for incurred expenses from $______
96 97-99 100-105

to $ _______;
106-111

_______ % of next $ _______;
112-114 115-120

_______ % of next $ _______;
121-123 124-129

_______ % of excess
130-~~162~~
132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

703 d. Describe coinsurance by the number of days (or visits).
1-3

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

704 e. Describe the application of the maximum dollar amount per day or visit
1-3 by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

___ Other
134

___ Remarks
135

___ Not determinable
136

___ Not applicable
137

___ Action code
138

705
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ 20 No dollar maximum pertaining to this section

___ 21 Unlimited dollar maximum

		Per Person Dollar amount
___ 27	Per day (or visit)	$___ 28-32
___ 33	Per six month period	$___ 34-40
___ 41	Per illness or confinement	$___ 42-49
___ 50	Per lifetime	$___ 51-60
___ 61	Per one year period	$___ 62-69
___ 70	Per two year period	$___ 71-78
___ 79	Per ___ (80-82) month	$___ 83-91

___ 92 Other

___ 93 Remarks

___ 94 Not determinable

___ 95 Not applicable

___ 96 Action code

706 g. Describe the maximum dollar amount payable for the specified categories
1-3 of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

Per Person
Dollar
amount

___ Per day (or visit) $_____
27 28-32

___ Per six month period $_____
33 34-40

___ Per illness or confinement $_____
41 42-49

___ Per lifetime $_____
50 51-60

___ Per one year period $_____
61 62-69

___ Per two year period $_____
70 71-78

___ Per _____ month $_____
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

710 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
____ 20	____ 21	Hospital Room and Board (in-hospital)
____ 22	____ 23	Hospital Miscellaneous Charges (in-hospital)
____ 24	____ 25	Extended care (extended care facility)
____ 26	____ 27	Extended care (home health care)
____ 28	____ 29	
____ 30	____ 31	Surgical care (in-hospital, not charged by hospital)
____ 32	____ 33	Surgical care (outpatient department)
____ 34	____ 35	Surgical care (non-hospital)
____ 36	____ 37	
____ 38	____ 39	Medical care (in-hospital, not charged by hospital)
____ 40	____ 41	Medical care (office)
____ 42	____ 43	Diagnostic X-ray and Lab Testing (in-hospital)
____ 44	____ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
____ 46	____ 47	Diagnostic X-ray and Lab Testing (non-hospital)

______ 48	______ 49	
______ 50	______ 51	Prescription Drugs (non-hospital)
______ 52	______ 53	Private Duty Nursing (in-hospital)
______ 54	______ 55	Private Duty Nursing (non-hospital)
______ 56	______ 57	
______ 58	______ 59	Mental Health Care (in-hospital)
______ 60	______ 61	Mental Health Care (in-hospital, not charged by hospital)
______ 62	______ 63	Mental Health Care (outpatient department)
______ 64	______ 65	Mental Health Care (non-hospital)
______ 66	______ 67	
______ 68	______ 69	Dental Care
______ 70	______ 71	Vision Care
______ 72	______ 73	Outpatient Care (accident and/or emergency sickness)
___ 74		Other
___ 75		Remarks
___ 76		Not determinable
___ 77		Not applicable
___ 78		Action code

711
1-3
b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ (62-63) month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ (90-92) % of earnings, with

$ ___ (93-96) maximum,

$ ___ (97-100) minimum

___ 101 $ ___ (102-104) for first ___ (105-107) days (or visits) and

$ ___ (108-110) for next ___ (111-113) days (or visits)

$ ___ (114-116) for next ___ (117-119) days (or visits)

___ 120 ___ (121-122) day deductible

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

712
1-3 c. Describe coinsurance by the amount of incurred expenses.

___ No application of coinsurance by amount of incurred expenses.
20

___ Plan pays _____ % for incurred expenses of $ _______ in excess
21 22-24 25-30

of basic benefits.

It then pays _____ % for an additional $ _______ of incurred expenses;
31-33 34-39

_____ % of next $ _______;
40-42 43-48

and _____ % in excess.
49-51

___ Plan pays _____ % for incurred expenses of $ _______ in excess
52 53-65 56-71

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays _____ % for an additional $ _______ of incurred expenses;
74-76 77-82

_____ % of next $ _______;
83-~~95~~ 86-~~102~~
85 92

_____ % in excess.
93-95

___ Plan pays ___ % for incurred expenses from $___
96 97-99 100-105

to $ ___;
106-111

___ % of next $ ___;
112-114 115-120

___ % of next $ ___;
121-123 124-129

___ % of excess
130-~~162~~
132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

713
1-3 d. Describe coinsurance by the number of days (or visits).

___ No application of coinsurance by number of days (or visits).
20

___ Plan pays _____ % of usual, reasonable, or customary charges
21 22-24

between _____ day and _____ day(s); then pays;
25-27 28-30

_____ % for next _____ day (s);
31-33 34-37

_____ % for next _____ day (s);
38-40 41-44

_____ % for next _____ day (s);
45-47 48-51

_____ % thereafter.
52-54

___ Plan pays _____ % of usual, reasonable, or customary charges
55 56-58

between _____ day and _____ day(s); then pays;
59-62 63-66

_____ % for next _____ day (s);
67-69 70-73

_____ % for next _____ day (s);
74-76 77-80

_____ % for next _____ day (s);
81-83 84-87

_____ % for next $ _____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

714 e. Describe the application of the maximum dollar amount per day or visit
1-3 by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

Other
$\overline{134}$

Remarks
$\overline{135}$

Not determinable
$\overline{136}$

Not applicable
$\overline{137}$

Action code
$\overline{138}$

715
1-3
g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

____ No dollar maximum pertaining to this section
20

____ Unlimited dollar maximum
21

Per Person
Dollar
amount

____ Per day (or visit) $______
27 28-32

____ Per six month period $______
33 34-40

____ Per illness or confinement $______
41 42-49

____ Per lifetime $______
50 51-60

____ Per one year period $______
61 62-69

____ Per two year period $______
70 71-78

____ Per ______ month $______
79 80-82 83-91

____ Other
92

____ Remarks
93

____ Not determinable
94

____ Not applicable
95

____ Action code
96

716 g. Describe the maximum dollar amount payable for the specified categorie
1-3 of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

Per Person
Dollar
amount

___ Per day (or visit) $_____
27 28-32

___ Per six month period $_____
33 34-40

___ Per illness or confinement $_____
41 42-49

___ Per lifetime $_____
50 51-60

___ Per one year period $_____
61 62-69

___ Per two year period $_____
70 71-78

___ Per _____ month $_____
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

720 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

____ 48	____ 49	
____ 50	____ 51	Prescription Drugs (non-hospital)
____ 52	____ 53	Private Duty Nursing (in-hospital)
____ 54	____ 55	Private Duty Nursing (non-hospital)
____ 56	____ 57	
____ 58	____ 59	Mental Health Care (in-hospital)
____ 60	____ 61	Mental Health Care (in-hospital, not charged by hospital)
____ 62	____ 63	Mental Health Care (outpatient department)
____ 64	____ 65	Mental Health Care (non-hospital)
____ 66	____ 67	
____ 68	____ 69	Dental Care
____ 70	____ 71	Vision Care
____ 72	____ 73	Outpatient Care (accident and/or emergency sickness)
____ 74		Other
____ 75		Remarks
____ 76		Not determinable
____ 77		Not applicable
____ 78		Action code

721
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

Per Person **Per Family**

___ No deductible
20

___ Per day (or visit) of $ ___.___
21 22-27

___ Per illness or confinement of $ ___.___
28 29-34

___ Deductible waived if expenses are incurred due to an accident
35

______
36-41

___ Per prescription $ ___.___
42 43-47

___ Per one year period of $ ___.___ or $ ___.___
48 49-54 55-60

___ Per ______ month period of $ ___.___ or $ ___.___
61 62-63 64-69 70-75

___ Per lifetime $ ___.___ or $ ___.___
76 77-82 83-88

___ ___.___ % of earnings, with
89 90-92

$ ______ maximum,
93-96

$ ______ minimum
97-100

___ $ ______ for first ______ days (or visits) and
101 102-104 105-107

$ ______ for next ______ days (or visits)
108-110 111-113

$ ______ for next ______ days (or visits)
114-116 117-119

___ ______ day deductible
120 121-122

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

722
1-3 c. Describe coinsurance by the amount of incurred expenses.

___ 20 No application of coinsurance by amount of incurred expenses.

___ 21 Plan pays _____ 22-24 % for incurred expenses of $ _______ 25-30 in excess of basic benefits.

It then pays _____ 31-33 % for an additional $ _______ 34-39 of incurred expenses;

_____ 40-42 % of next $ _______ 43-48 ;

and _____ 49-51 % in excess.

___ 52 Plan pays _____ 53-65 % for incurred expenses of $ _______ 56-71 in excess of basic benefits or a major medical "integrated" deductible of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan pays _____ 74-76 % for an additional $ _______ 77-82 of incurred expenses;

_____ 83-~~95~~ 85 % of next $ _______ 86-~~102~~ 92 ;

_____ 93-95 % in excess.

___ Plan pays _____ % for incurred expenses from $______
96 97-99 100-105

to $ ______;
106-111

______ % of next $ ______;
112-114 115-120

______ % of next $ ______;
121-123 124-129

______ % of excess
130-~~162~~
132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

723 1-3 d. Describe coinsurance by the number of days (or visits).

___ 20 No application of coinsurance by number of days (or visits).

___ 21 Plan pays ____ 22-24 % of usual, reasonable, or customary charges

between ____ 25-27 day and ____ 28-30 day(s); then pays;

____ 31-33 % for next ____ 34-37 day (s);

____ 38-40 % for next ____ 41-44 day (s);

____ 45-47 % for next ____ 48-51 day (s);

____ 52-54 % thereafter.

___ 55 Plan pays ____ 56-58 % of usual, reasonable, or customary charges

between ____ 59-62 day and ____ 63-66 day(s); then pays;

____ 67-69 % for next ____ 70-73 day (s);

____ 74-76 % for next ____ 77-80 day (s);

____ 81-83 % for next ____ 84-87 day (s);

____ 88-90 % for next $ ____ 91-97 of incurred expenses.

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

724
1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

____ Other
134

____ Remarks
135

____ Not determinable
136

____ Not applicable
137

____ Action code
138

725
1-3

g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

		Per Person Dollar amount
___ 20	No dollar maximum pertaining to this section	
___ 21	Unlimited dollar maximum	
___ 27	Per day (or visit)	$___ 28-32
___ 33	Per six month period	$___ 34-40
___ 41	Per illness or confinement	$___ 42-49
___ 50	Per lifetime	$___ 51-60
___ 61	Per one year period	$___ 62-69
___ 70	Per two year period	$___ 71-78
___ 79	Per ___ month 80-82	$___ 83-91
___ 92	Other	
___ 93	Remarks	
___ 94	Not determinable	
___ 95	Not applicable	
___ 96	Action code	

726
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

___
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$___ 28-32
___ 33	Per six month period	$___ 34-40
___ 41	Per illness or confinement	$___ 42-49
___ 50	Per lifetime	$___ 51-60
___ 61	Per one year period	$___ 62-69
___ 70	Per two year period	$___ 71-78
___ 79	Per ___ (80-82) month	$___ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

730 Categories of covered expenses
1-3

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
____ 20	____ 21	Hospital Room and Board (in-hospital)
____ 22	____ 23	Hospital Miscellaneous Charges (in-hospital)
____ 24	____ 25	Extended care (extended care facility)
____ 26	____ 27	Extended care (home health care)
____ 28	____ 29	
____ 30	____ 31	Surgical care (in-hospital, not charged by hospital)
____ 32	____ 33	Surgical care (outpatient department)
____ 34	____ 35	Surgical care (non-hospital)
____ 36	____ 37	
____ 38	____ 39	Medical care (in-hospital, not charged by hospital)
____ 40	____ 41	Medical care (office)
____ 42	____ 43	Diagnostic X-ray and Lab Testing (in-hospital)
____ 44	____ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
____ 46	____ 47	Diagnostic X-ray and Lab Testing (non-hospital)

726 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.
1-3

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per _____ month 80-82	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

$\frac{730}{1-3}$ Categories of covered expenses

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

731
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
__ 20	No deductible		
__ 21	Per day (or visit) of	$ __.__ 22-27	
__ 28	Per illness or confinement of	$ __.__ 29-34	
__ 35	Deductible waived if expenses are incurred due to an accident		
__ 36-41			
__ 42	Per prescription	$ __.__ 43-47	
__ 48	Per one year period of	$ __.__ 49-54	or $ __.__ 55-60
__ 61	Per __ 62-63 month period of	$ __.__ 64-69	or $ __.__ 70-75
__ 76	Per lifetime	$ __.__ 77-82	or $ __.__ 83-88

__ 89 __.__ 90-92 % of earnings, with

$ __ 93-96 maximum,

$ __ 97-100 minimum

__ 101 $ __ 102-104 for first __ 105-107 days (or visits) and

$ __ 108-110 for next __ 111-113 days (or visits)

$ __ 114-116 for next __ 117-119 days (or visits)

__ 120 __ 121-122 day deductible

Other
$\overline{123}$

Remarks
$\overline{124}$

Not determinable
$\overline{125}$

Action code
$\overline{126}$

732
1-3
c. Describe coinsurance by the amount of incurred expenses.

____ No application of coinsurance by amount of incurred expenses.
20

____ Plan pays ____ % for incurred expenses of $ ______ in excess
21 22-24 25-30

of basic benefits.

It then pays ____ % for an additional $ ______ of incurred expenses;
31-33 34-39

____ % of next $ ______;
40-42 43-48

and ____ % in excess.
49-51

____ Plan pays ____ % for incurred expenses of $ ______ in excess
52 53-65 56-71

of basic benefits or a major medical "integrated" deductible

of $ ____.__ per person or $ ____.__ per family; then plan
62-67 68-73

pays ____ % for an additional $ ______ of incurred expenses;
74-76 77-82

____ % of next $ ______;
83-~~95~~ 86-~~102~~
85 92

____ % in excess.
93-95

___ Plan pays _____ % for incurred expenses from $______
96 97-99 100-105

to $ _______;
106-111

_______ % of next $ _______;
112-114 115-120

_______ % of next $ _______;
121-123 124-129

_______ ~~% of excess~~
130-~~162~~
132

___ Other
133

___ Remarks
134

___ Not determinable
135

___ Not applicable
136

___ Action code
137

733
1-3 d. Describe coinsurance by the number of days (or visits).

___ 20 No application of coinsurance by number of days (or visits).

___ 21 Plan pays _____ 22-24 % of usual, reasonable, or customary charges

between _____ 25-27 day and _____ 28-30 day(s); then pays;

_____ 31-33 % for next _____ 34-37 day (s);

_____ 38-40 % for next _____ 41-44 day (s);

_____ 45-47 % for next _____ 48-51 day (s);

_____ 52-54 % thereafter.

___ 55 Plan pays _____ 56-58 % of usual, reasonable, or customary charges

between _____ 59-62 day and _____ 63-66 day(s); then pays;

_____ 67-69 % for next _____ 70-73 day (s);

_____ 74-76 % for next _____ 77-80 day (s);

_____ 81-83 % for next _____ 84-87 day (s);

_____ 88-90 % for next $ _____ 91-97 of incurred expenses.

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

734 e. Describe the application of the maximum dollar amount per day or visit
1-3 by the number of days or visits.

___ No application of the maximum dollar amount by the number
20 of days or visits.

___ Maximum $ _____ per day (or visit) for the first _____ day(s);
21 22-25 26-29

$ _____ per day for the next _____ day (s);
30-33 34-37

$ _____ per day for the next _____ day (s);
38-41 42-45

$ _____ per day for the next _____ day (s);
46-49 50-53

$ _____ per day for the next _____ day (s);
54-57 58-61

$ _____ per day for the next _____ day (s);
62-65 66-69

$ _____ thereafter.
70-73

___ Maximum $ _____ per day (or visit) for the first _____
74 75-78 79-82
day (s);

$ _____ per day for the next _____ day (s);
83-86 87-90

$ _____ per day for the next _____ day (s);
91-94 95-98

$ _____ per day for the next _____ day (s);
99-102 103-106

$ _____ per day for the next _____ day (s);
107-110 111-114

$ _____ per day for the next _____ day (s);
115-118 119-122

$ _____ per day for the next $ _____ of incurred expenses.
123-126 127-133

Other
$\overline{134}$

Remarks
$\overline{135}$

Not determinable
$\overline{136}$

Not applicable
$\overline{137}$

Action code
$\overline{138}$

735
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

		Per Person Dollar amount	
___ 27	Per day (or visit)	$___ 28-32	
___ 33	Per six month period	$___ 34-40	$___ 41-48
___ 41	Per illness or confinement	$___ 42-49	
___ 50	Per lifetime	$___ 51-60	
___ 61	Per one year period	$___ 62-69	
___ 70	Per two year period	$___ 71-78	
___ 79	Per ___ (80-82) month	$___ 83-91	

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

736
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

		Per Person Dollar amount
___ 27	Per day (or visit)	$_____ 28-32
___ 33	Per six month period	$_____ 34-40
___ 41	Per illness or confinement	$_____ 42-49
___ 50	Per lifetime	$_____ 51-60
___ 61	Per one year period	$_____ 62-69
___ 70	Per two year period	$_____ 71-78
___ 79	Per _____ (80-82) month	$_____ 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

740
1-3 Categories of covered expenses

a. Check appropriate categories of expenses that apply to this set of questions.

Basic Benefit	Major Medical	Category of Expenses
______ 20	______ 21	Hospital Room and Board (in-hospital)
______ 22	______ 23	Hospital Miscellaneous Charges (in-hospital)
______ 24	______ 25	Extended care (extended care facility)
______ 26	______ 27	Extended care (home health care)
______ 28	______ 29	
______ 30	______ 31	Surgical care (in-hospital, not charged by hospital)
______ 32	______ 33	Surgical care (outpatient department)
______ 34	______ 35	Surgical care (non-hospital)
______ 36	______ 37	
______ 38	______ 39	Medical care (in-hospital, not charged by hospital)
______ 40	______ 41	Medical care (office)
______ 42	______ 43	Diagnostic X-ray and Lab Testing (in-hospital)
______ 44	______ 45	Diagnostic X-ray and Lab Testing (outpatient dep't.)
______ 46	______ 47	Diagnostic X-ray and Lab Testing (non-hospital)

48	49	
50	51	Prescription Drugs (non-hospital)
52	53	Private Duty Nursing (in-hospital)
54	55	Private Duty Nursing (non-hospital)
56	57	
58	59	Mental Health Care (in-hospital)
60	61	Mental Health Care (in-hospital, not charged by hospital)
62	63	Mental Health Care (outpatient department)
64	65	Mental Health Care (non-hospital)
66	67	
68	69	Dental Care
70	71	Vision Care
72	73	Outpatient Care (accident and/or emergency sickness)
74		Other
75		Remarks
76		Not determinable
77		Not applicable
78		Action code

741
1-3 b. Describe the deductible applied to the specified categories of expenses. Check appropriate spaces and enter the dollar and cent amount.

		Per Person	Per Family
___ 20	No deductible		
___ 21	Per day (or visit) of	$ ___.___ 22-27	
___ 28	Per illness or confinement of	$ ___.___ 29-34	
___ 35	Deductible waived if expenses are incurred due to an accident		
___ 36-41			
___ 42	Per prescription	$ ___.___ 43-47	
___ 48	Per one year period of	$ ___.___ 49-54	or $ ___.___ 55-60
___ 61	Per ___ 62-63 month period of	$ ___.___ 64-69	or $ ___.___ 70-75
___ 76	Per lifetime	$ ___.___ 77-82	or $ ___.___ 83-88

___ 89 ___.___ 90-92 % of earnings, with

$ ___ 93-96 maximum,

$ ___ 97-100 minimum

___ 101 $ ___ 102-104 for first ___ 105-107 days (or visits) and

$ ___ 108-110 for next ___ 111-113 days (or visits)

$ ___ 114-116 for next ___ 117-119 days (or visits)

___ 120 ___ 121-122 day deductible

Other
___
123

Remarks
___
124

Not determinable
___
125

Action code
___
126

742
1-3 c. Describe coinsurance by the amount of incurred expenses.

____ 20 No application of coinsurance by amount of incurred expenses.

____ 21 Plan pays ______ 22-24 % for incurred expenses of $ ________ 25-30 in excess

of basic benefits.

It then pays ______ 31-33 % for an additional $ ________ 34-39 of incurred expenses;

______ 40-42 % of next $ ________ 43-48;

and ______ 49-51 % in excess.

____ 52 Plan pays ______ 53-65 % for incurred expenses of $ ________ 56-71 in excess

of basic benefits or a major medical "integrated" deductible

of $ ____.__ 62-67 per person or $ ____.__ 68-73 per family; then plan

pays ______ 74-76 % for an additional $ ________ 77-82 of incurred expenses;

______ 83-~~9~~5 8 % of next $ ________ 86-~~102~~ 92;

______ 93-95 % in excess.

____ 96 Plan pays ____ 97-99 % for incurred expenses from $ ____ 100-105

to $ ____ 106-111;

____ 112-114 % of next $ ____ 115-120;

____ 121-123 % of next $ ____ 124-129;

____ 130-~~162~~ 132 % of excess

____ 133 Other

____ 134 Remarks

____ 135 Not determinable

____ 136 Not applicable

____ 137 Action code

743 d. Describe coinsurance by the number of days (or visits).
1-3

____ No application of coinsurance by number of days (or visits).
20

____ Plan pays ____ % of usual, reasonable, or customary charges
21 22-24

between ____ day and ____ day(s); then pays;
25-27 28-30

____ % for next ____ day (s);
31-33 34-37

____ % for next ____ day (s);
38-40 41-44

____ % for next ____ day (s);
45-47 48-51

____ % thereafter.
52-54

____ Plan pays ____ % of usual, reasonable, or customary charges
55 56-58

between ____ day and ____ day(s); then pays;
59-62 63-66

____ % for next ____ day (s);
67-69 70-73

____ % for next ____ day (s);
74-76 77-80

____ % for next ____ day (s);
81-83 84-87

____ % for next $ ____ of incurred expenses.
88-90 91-97

___ Other
98

___ Remarks
99

___ Not determinable
100

___ Not applicable
101

___ Action code
102

744
1-3 e. Describe the application of the maximum dollar amount per day or visit by the number of days or visits.

_____ 20 No application of the maximum dollar amount by the number of days or visits.

_____ 21 Maximum $ _____ 22-25 per day (or visit) for the first _____ 26-29 day(s);

$ _____ 30-33 per day for the next _____ 34-37 day (s);

$ _____ 38-41 per day for the next _____ 42-45 day (s);

$ _____ 46-49 per day for the next _____ 50-53 day (s);

$ _____ 54-57 per day for the next _____ 58-61 day (s);

$ _____ 62-65 per day for the next _____ 66-69 day (s);

$ _____ 70-73 thereafter.

_____ 74 Maximum $ _____ 75-78 per day (or visit) for the first _____ 79-82 day (s);

$ _____ 83-86 per day for the next _____ 87-90 day (s);

$ _____ 91-94 per day for the next _____ 95-98 day (s);

$ _____ 99-102 per day for the next _____ 103-106 day (s);

$ _____ 107-110 per day for the next _____ 111-114 day (s);

$ _____ 115-118 per day for the next _____ 119-122 day (s);

$ _____ 123-126 per day for the next $ _____ 127-133 of incurred expenses.

Other
$\overline{134}$

Remarks
$\overline{135}$

Not determinable
$\overline{136}$

Not applicable
$\overline{137}$

Action code
$\overline{138}$

745
1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___
20 No dollar maximum pertaining to this section

___
21 Unlimited dollar maximum

		Per Person Dollar amount
___ 27	Per day (or visit)	$___ 28-32
___ 33	Per six month period	$___ 34-40
___ 41	Per illness or confinement	$___ 42-49
___ 50	Per lifetime	$___ 51-60
___ 61	Per one year period	$___ 62-69
___ 70	Per two year period	$___ 71-78
___ 79	Per ___ month 80-82	$___ 83-91

___
92 Other

___
93 Remarks

___
94 Not determinable

___
95 Not applicable

___
96 Action code

746/1-3 g. Describe the maximum dollar amount payable for the specified categories of covered expenses. Check appropriate spaces and enter the dollar amount.

___ No dollar maximum pertaining to this section
20

___ Unlimited dollar maximum
21

_____
22-26

Per Person
Dollar
amount

___ Per day (or visit) $_____
27 28-32

___ Per six month period $_____
33 34-40

___ Per illness or confinement $_____
41 42-49

___ Per lifetime $_____
50 51-60

___ Per one year period $_____
61 62-69

___ Per two year period $_____
70 71-78

___ Per _____ month $_____
79 80-82 83-91

___ Other
92

___ Remarks
93

___ Not determinable
94

___ Not applicable
95

___ Action code
96

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